Canadian Hospital

Journal of The Canadian Hospital Association

March, 1960

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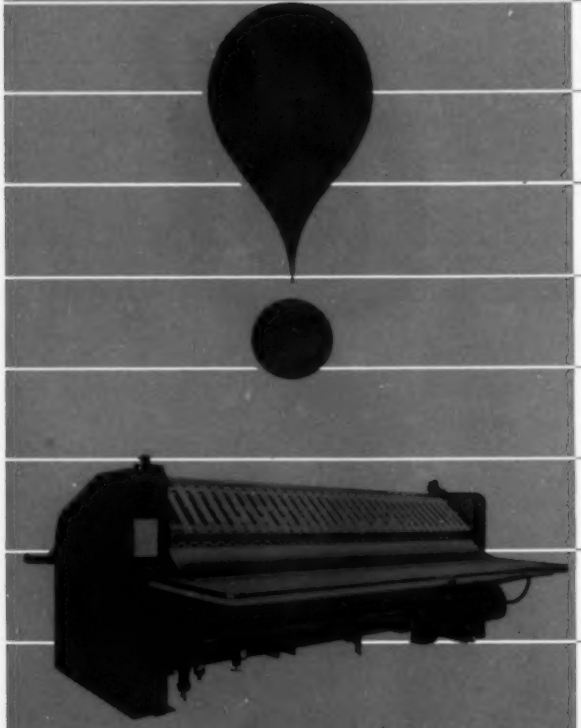

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The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

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Contents

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Cover picture — St. Joseph's General Hospital, North Bay, Ont.

(For Subscription Rates See Page 28)

Business Manager: Charles A. Edwards
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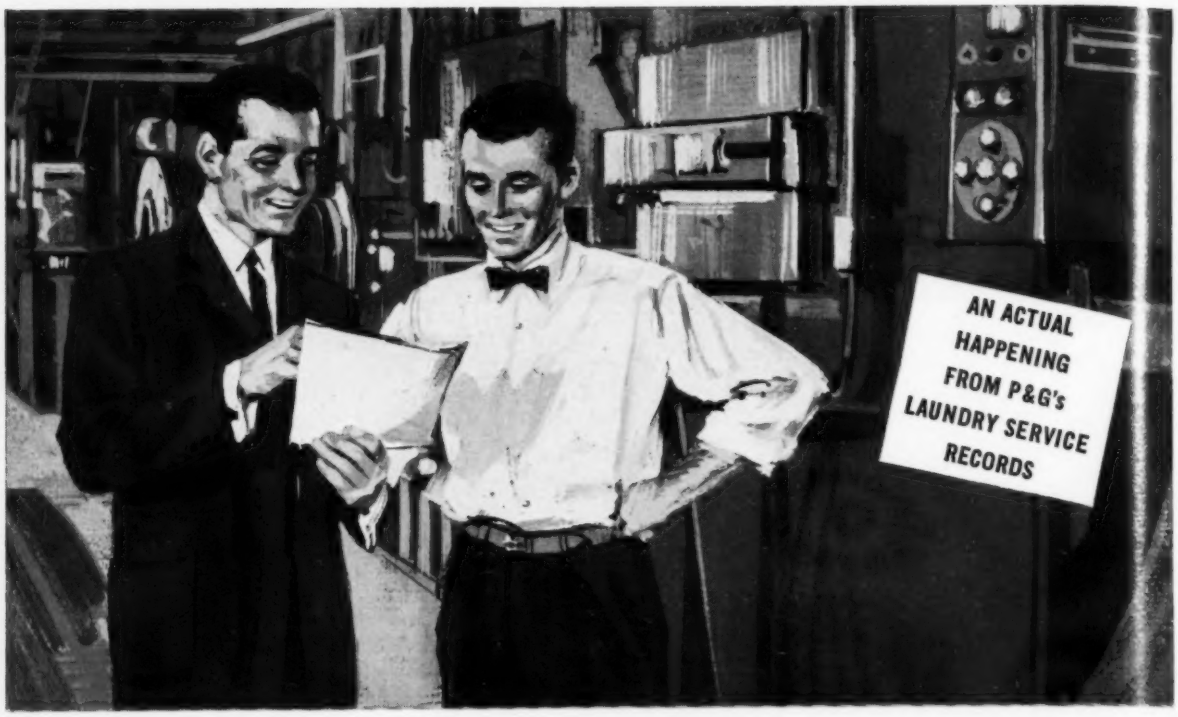

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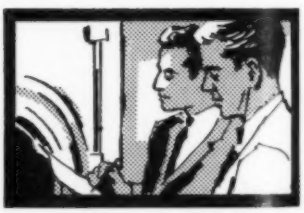

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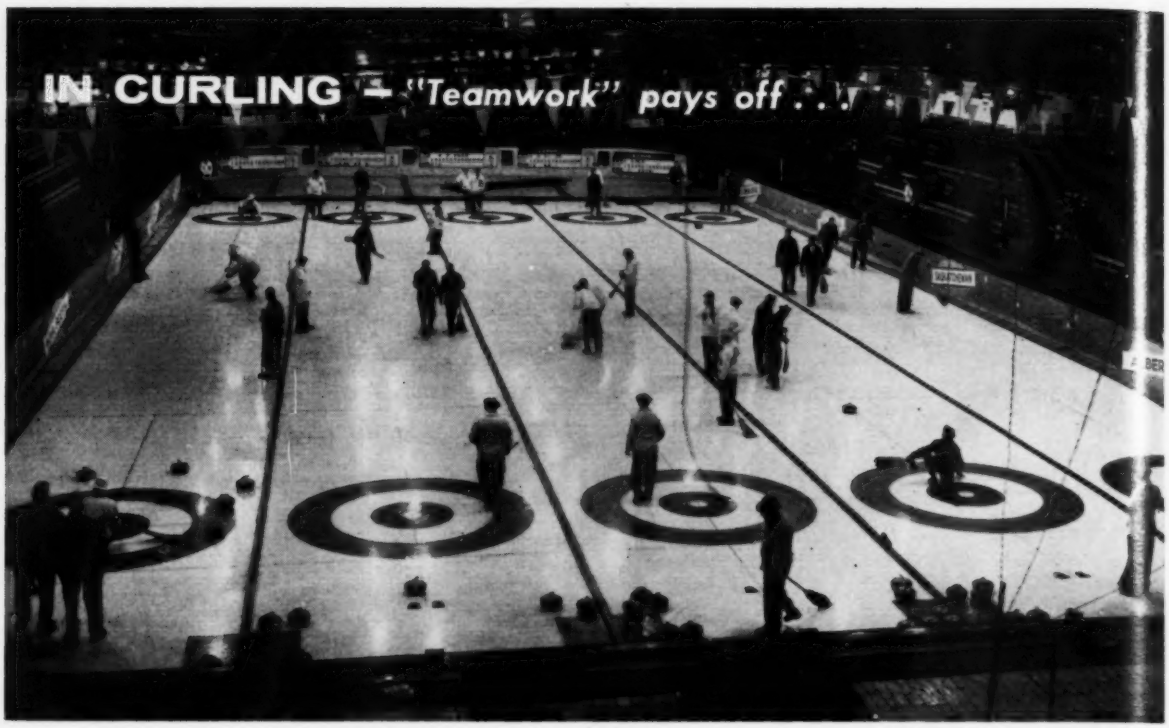

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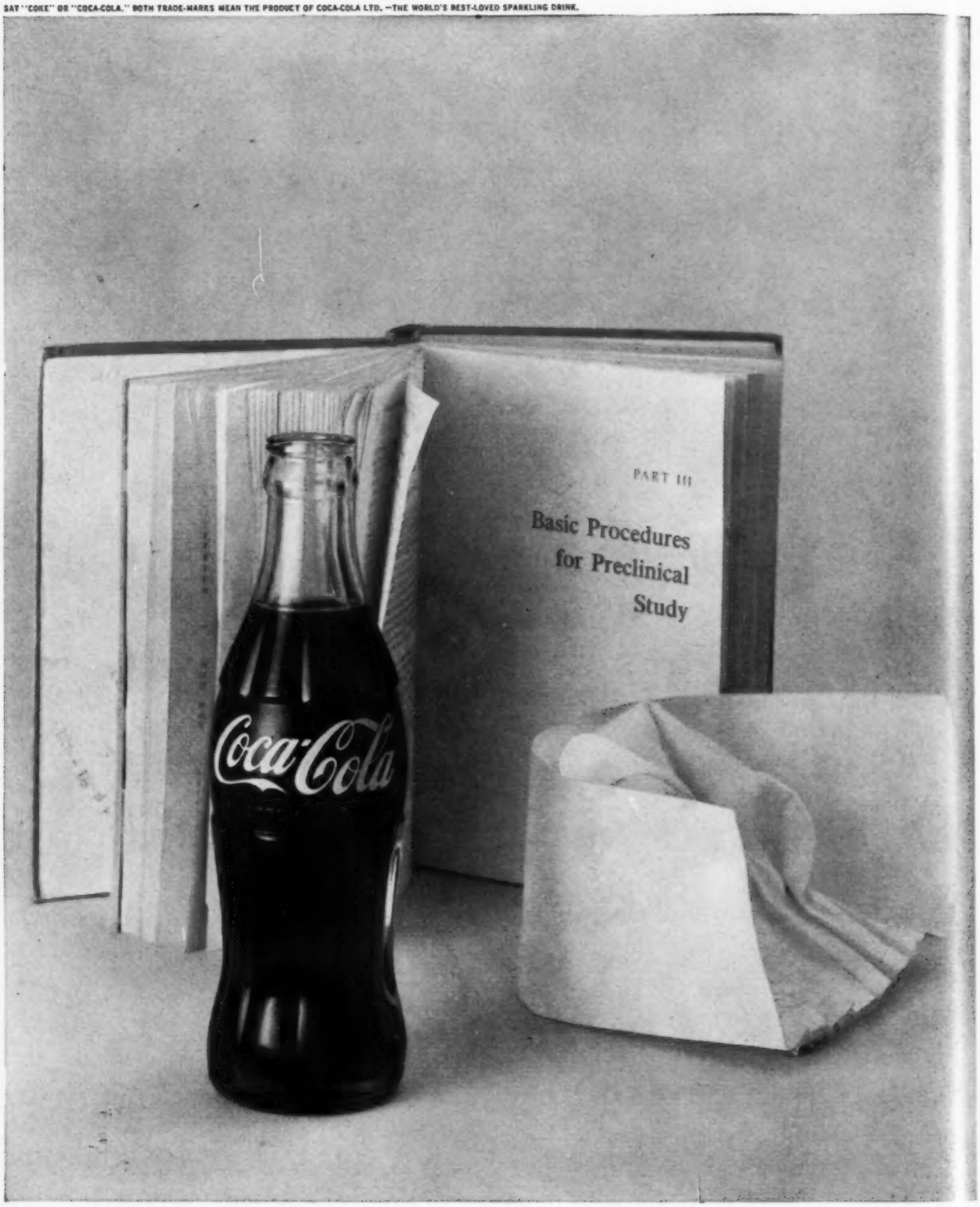

When too many tasks seem to crowd the unyielding hours,
a welcome "pause that refreshes" with ice-cold Coca-Cola
often puts things into manageable order.

Notes About People

In Abbotsford, B.C.

The new administrator of the Matsqui-Sumas-Abbotsford General Hospital, Abbotsford, B.C., is H. S. Collins. He succeeds F. L. Connon. Before this appointment Mr. Collins was the administrator of the Nicola Valley General Hospital, Merritt, B.C.

R.N.A.O. Appointment

Albert Wedgery has been appointed to the staff of the Registered Nurses' Association of Ontario. His title will be assistant secretary, education and service. Mr. Wedgery trained at the Ontario Hospital, Whitby, school of nursing and took post-graduate work at the University of Toronto. He is now studying for his bachelor of science degree in nursing.

Mr. Wedgery has always been very interested in R.N.A.O. affairs, and has played a leading rôle in seeking recognition for male nurses and in promoting the idea of nursing as a career for men.

At the W.C.B.

The Workmen's Compensation Board has appointed Donald L. Palmer as medical aid officer. Born in Toronto, Mr. Palmer received his education there.

In September 1942 he joined the head office staff of the Board, working in the claims department. Except for a period of service with the Canadian army, he has been with that department ever since.

Mr. Palmer succeeds Andrew McCartney who is now on the staff of the Ontario Hospital Services Commission.

Medical Director at Toronto Western Hospital

R. J. Nodwell, M.D., former assistant surgeon general for hospitals and finance with the Canadian Forces Medical Services, Ottawa, has been appointed medical director at the Toronto Western Hospital, Toronto, Ont. Dr. Nodwell is a graduate (1932) of the University of Toronto's faculty of medicine.

He has served on the staff of the Royal Jubilee Hospital, Victoria, B.C. and later was staff doctor at the Pacific cable station on Midway Island. Later he joined the militia and was transferred to the permanent force of the Royal Canadian Army Medical Corps. He was stationed with the R.C.N. Pacific Coast and later with the R.C.A.F. at Vancouver and Ottawa. During the second world war, Dr. Nodwell served overseas. After the war he

R. J. Nodwell, M.D.

supervised the closing of the last Canadian hospital in England and returned to Canada in October 1946.

Dr. Nodwell was then appointed commanding officer of the Toronto Military Hospital at Chorley Park and in 1948 was acting command medical officer for the central command. After two years as area medical officer in British Columbia he went to Washington as medical liaison officer to the Armed Forces of the United States. He returned to Canada in 1953 as Deputy Director General of Medical Services for the Canadian army, a post he held for six years.

Nursing Chairman

Edith Dick, director of the nursing branch, Ontario Department of Health, has been appointed chairman of the Volunteer Nursing Service, Ontario division, the Canadian Red Cross Society.

Born and educated in Milton, Miss Dick received her nursing training at the Johns Hopkins Hospital school of nursing in Baltimore, Md., where she served on the staff. She holds a bachelor's degree and a certificate in public health nursing from the University of Toronto. She joined the nursing branch of the Health Department in 1935 and for several years was inspector of nursing schools.

During the second world war, Miss Dick spent 4½ years with the Royal Canadian Army Medical Corps. As matron of the No. 10 Canadian General Hospital, she held the rank of major and in 1944 received the Royal Red Cross, first class.

Miss Dick has been a member of the Ontario division nursing committee, Red Cross, since 1945 and was appointed to the bursary committee in 1946.

New Executive Director St. Elizabeth Nurses

Anne-Marie Quigley has been named executive director of the St. Elizabeth Visiting Nurses' Association. She succeeds Helen Heffernan who retired recently after 33 years with the association.

Born in Toronto, Miss Quigley was educated at St. Joseph's Convent. She is a graduate of St. Michael's Hospital school of nursing and has done postgraduate work at the University of Toronto.

She has taken a course in obstetrics at St. Michael's Hospital and was obstetrical supervisor there for four years. After she obtained her certificate in public health, she worked for eight years with the York County Health Unit.

P.A.H.O. Appointment

The Pan American Health Organization has appointed Dr. Robert Kohn of Ottawa as a consultant in public health statistics. He will be the official consultant in public health statistics to the health administrations of Venezuela and the islands of the Caribbean associated with France, the Netherlands, the United Kingdom and the United States. His duty station will be Kingston, Jamaica.

Agnes Curr Girvan

Mrs. Richard Girvan died recently at the age of 31. She was a clinical instructor at Toronto Western Hospital.

After graduating in 1950 from the Toronto Western Hospital's school of nursing, Mrs. Girvan took

(concluded on page 20)

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People

(concluded from page 14)

a postgraduate course at the University of Toronto. Afterwards she worked in a supervisory capacity in Santa Monica, Calif., and in Edmonton, before she joined the staff of the Toronto Western Hospital in 1955.

Change at Ladysmith

Ian K. Peddie, the former administrator of the Windermere District Hospital, Invermere, B.C., has taken up the position of administrator at the Ladysmith General Hospital, Ladysmith, B.C. He replaces John Simons who resigned late last year.

Max Thorek

Dr. Max Thorek, widely known as the founder and secretary general of the International College of Surgeons died in January at the age of 79. Dr. Thorek was also the founder of the American Hospital, Chicago, professor of surgery at Cook County Graduate School of Medicine, editor of the Journal of the International College of Surgeons, and author of numerous medical books and articles.

Gladys Richards

Colonel Gladys Richards, a Salvation Army officer and former director of nursing at Grace Hospital, Windsor, died recently at the age of 54. She was married in 1958 after having served 30 years at the hospital.

• Life membership in the American Hospital Association has been granted to a Canadian member of the association for 30 years, Chester C. Woods, Toronto architect.

• Mrs. G. Heal has been elected president for 1960 of the Registered Nurses' Association of Manitoba.

• Dr. R. Murphy has been elected chief of the medical staff at the Campbell River and District General Hospital, Campbell River, B.C. He succeeds Dr. Bathurst Hall.

• Robert Neal has joined the staff of the Quill Plains Regional Hospital Council, Humboldt, Sask. He has had considerable experience with hospital and allied work, particularly auditing. Russell Dagenais, R.N., who, for the past four years has been employed as clinical instructor at St. Elizabeth's Hospital, Humboldt, has also joined the staff —as a nursing consultant. He has taken a one-year post-graduate course in nursing administration and supervision at the University of Saskatchewan.

• S. Stoddart has begun new duties as personnel officer at the Kitchener-Waterloo Hospital, Kitchener, Ont.

Ian K. Peddie, the former administrator, M.D.C.M., F.R.C.P., of Charlottetown, P.E.I., has been awarded the gold medal in medicine by the Royal College of Physicians and Surgeons of Canada for the best thesis submitted in its annual contest.

• R. MacD. Black, chairman of the Nova Scotia Hospital Insurance Commission, has resigned. Mr. Black will resume his law practice on a full-time basis.

• Lucien L. Coutu, M.D., Ph.D., F.R.C.P. (C) has been named medical director of Hôtel Dieu de Montréal, Que. He replaces Dr. Gaston Gosselin.

• Dr. Wilfrid Melançon is the new medical director at Hôpital Ste-Croix, Drummondville, Que. He succeeds Dr. Hubert St-Pierre.

Canadian Hospital

The Canadian Hospital is published monthly by the Canadian Hospital Association as its official journal devoted to the hospital field across Canada.

The subscription rate in Canada, U.S.A., and Gt. Britain is $3.00 per year. The rate for each additional subscription to hospitals or organizations having a regular subscription (and personal subscription for individuals directly associated with them) is $1.50 per year. The rate to other countries is $3.50 per year. Single copies when available, are supplied at 50c each.

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Canada Year Book

The 1959 edition of the valuable *Canada Year Book* has been released. The cloth-bound edition is $5.00 per copy and a limited number of paper-bound copies are available at a price of $1.50 to bona fide teachers, university students and ministers of religion.

Either edition may be purchased from the Department of Public Printing and Stationery, Ottawa, Ont., or from the Dominion Bureau of Statistics, Ottawa.

Civil Defence Course

Directors of nursing from 18 hospitals attended a four-day civil defence course. The "Emergency Health Service" course was planned jointly by the provinical health department and the provincial civil defence branch. Dr. Gordon Fryer, Ottawa, medical consultant to the federal emergency health service, attended the meetings in an advisory capacity. The course included such subjects as radiation, fire prevention, organization of food supplies, responsibilities of the army, civil defence measures, evacuation of patients and discussions from federal, provincial health departments as well as the rôle of the B.C. Hospital Insurance Service.

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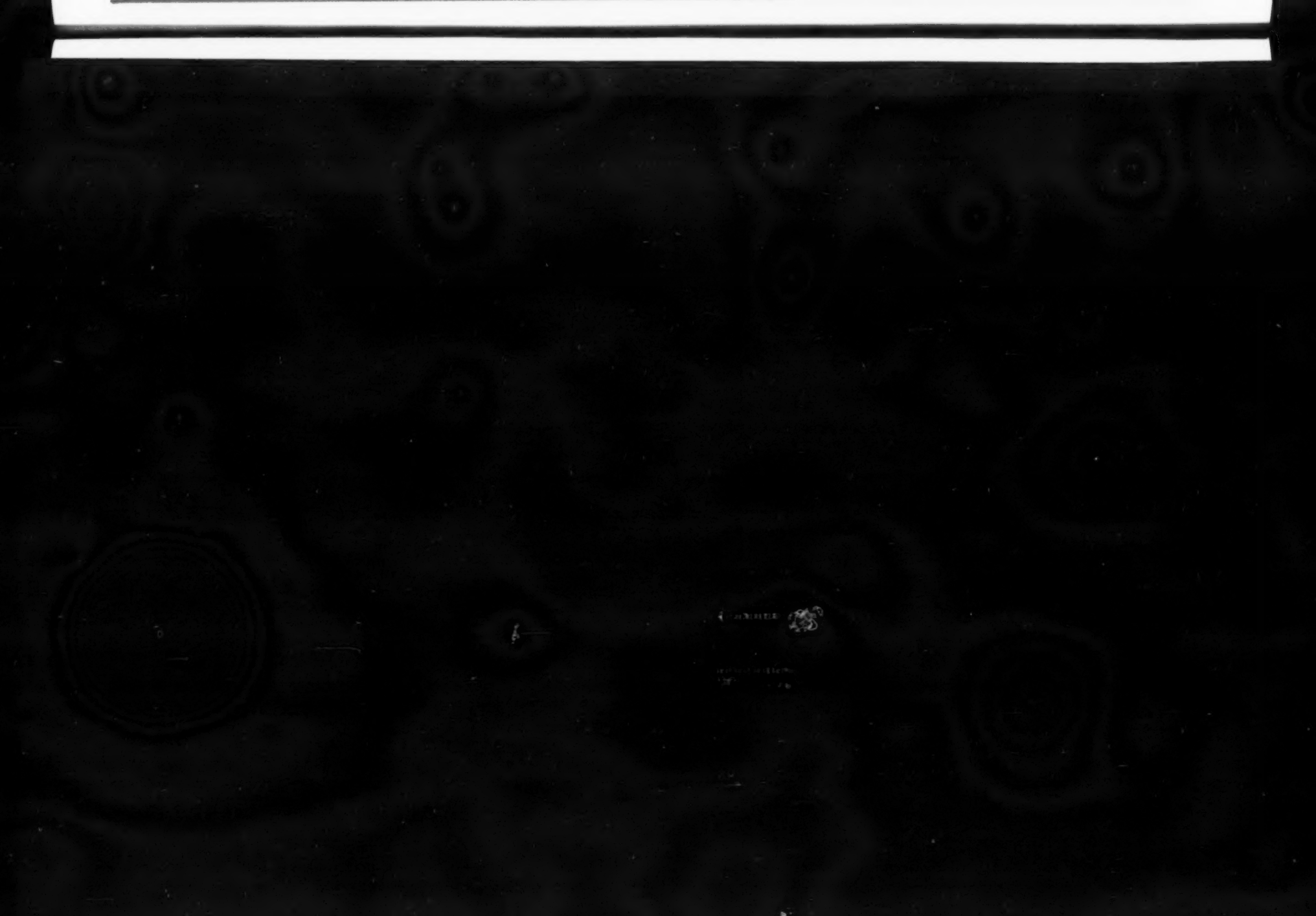

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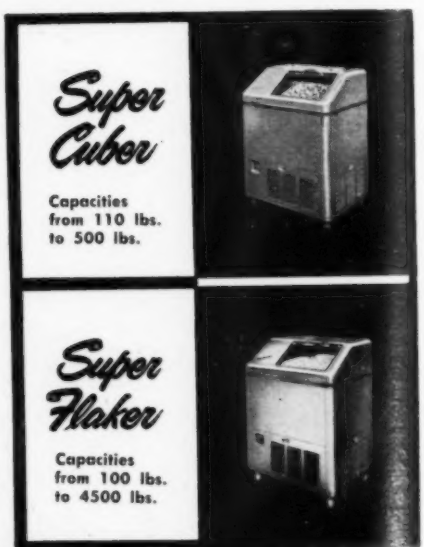

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W. Douglas Piercey, M.D., Editor

Canadian Hospital

Obiter Dicta

Education Is News

RECENTLY one of our larger daily papers published an editorial under the above heading, with the comment that never before in this country has so much print been devoted to ways and means of upholding a high standard of education for a rapidly expanding population. The reference was to our schools in general and to our bulging universities which are also increasing in number. But interest in adult education of every type is quickened, too, as Canada tries to cope with the needs of new citizens from many lands and native-born people who wish to improve their vocational status.

And nowhere is this interest in education more apparent than in the hospital and health fields. The reasons are obvious and to reiterate them here would be witless. A glance at the classified advertisements in professional journals or the lay press tells the story. More and better trained people are needed in almost every category and opportunities for education are opening across the country, almost in waves. Each day we hear of new in-service programs for hospital personnel in various departments and in hospitals all over the country. For instance, Toronto Western Hospital recently held a three-day workshop for its nursing staff, having as its theme "Toward Better Patient Care". These sessions will receive further mention in a subsequent issue of this journal. Coming up in May is a basic institute for hospital administrators sponsored by the Ontario Hospital Association and the American College of Hospital Administrators and there will be others throughout the year. The Canadian Medical Association has recently announced a program under which that association will approve hospital schools for radiological technicians, an encouraging step forward for this group of hospital personnel. The Canadian Society of Laboratory Technologists, together with this association, hopes to lay on a one-week program to assist chief hospital technologists in their teaching; and the Department of Bacteriology at McGill University is offering a four-week course in medical mycology for laboratory workers. And so runs the news.

In Canada there are two programs for the formal training of hospital administrators, at the University of Toronto and at the University of Montreal. In this issue Kenneth S. McLaren discusses the twelve years' experience with this training at the former university and the rôle being played by its graduates in the hospital field. In another article, Dr. A. L. Swanson of the University Hospital in Saskatoon outlines the new course being inaugurated at the University of Saskatchewan for secretary-managers of small hospitals who are now in the field. Lawrence L. Wilson of this association reports on our own educational activities during the past year. The highlight of that discourse is the announcement that the C.H.A. and the Canadian Nurses' Association are to establish an extension course for head nurses.

If education in the general sense has as its aim "to develop the person as a person" it has the same aim in the hospital field but with always the added objective that it leads to better patient care.—*J.F.*

Canadian Hospital Directory 1960

YOUR association is now busily engaged in the production of the 1960 *Canadian Hospital Directory*. Publication of this, the eighth edition of the directory, is scheduled for May 1st. It was in 1953, with the

co-operation of hospital people, associations, educational authorities, governments, and others, that we published the first edition. Conceived as a service to the field, the directory is designed to offer several categories of information for ready reference.

The expansion of hospital services is so rapid these days that it is very difficult to keep source books up to date. However, one of the strong points about the *Canadian Hospital Directory* is that we are able to publish information while it is still current. Because there are changes from year to year in hospital personnel, beds set up, and other data, it is necessary to revise all information annually if the directory is to serve its purpose as a reference book. It is only possible to do so through the continuing co-operation of all hospitals, government departments, and associations which supply us with the required data.

Those administrators who fill out our annual survey form may wonder why we ask for more information than is actually included in the directory and why it is required in triplicate. Through an arrangement among the Canadian Hospital Association, the American Hospital Association, and some provincial hospital associations, a composite form has been designed to bring in information required by all these groups. This survey form then mitigates the possibility that hospitals might be asked to fill out these forms at separate times. Your national association keeps one copy for its own purposes, forwards one copy to the A.H.A., and one copy to provincial associations requesting this information about the hospitals in their province. At your national association headquarters, a file is kept on every hospital in Canada and quite often the information on the survey forms proves very useful to us, apart from its obvious use during production of the current directory.

It is our urgent desire to keep information in the directory as accurate and up-to-date as possible. Over the years we have been impressed and heartened by the high percentage of returns we receive promptly from hospitals. If, however, a hospital does not return its forms on time, we have no other recourse but to repeat the information published the previous year. We are now approaching the deadline for compilation of this material. If you have not already returned your forms to this office, it would be appreciated if you would do so immediately. Thank you.

Have You Ordered Your Copy of CHAM?

THE immediate and enthusiastic response which greeted the arrival of the second edition of CHAM on the hospital scene was indicative of a need for such a manual. Designed as a means of standardizing hospital accounting procedures and as an aid to the hospital accountant and administrator in recording and classifying the day-to-day activities of the hospital, CHAM merits a place on the library shelf of every hospital executive. If you have not already ordered your copy of the second edition of CHAM and thus taken your place in the forward progress of hospital accounting, we would most sincerely urge you to do so.

Accounting has often been described as the language of finance—with the accountant as interpreter. It provides the factual information which permits the hospital administrator to make decisions necessary for the operation of his institution. However it does more than this. It should also provide a means of financial control. The *Canadian Hospital Accounting Manual* sets forth a uniform accounting system which, if properly applied, should achieve these ends.

Accounting and statistical facts can be compared only if they are consistent and uniform. This means that in order to compare one year's activities with those of a preceding year, it is necessary that similar transactions be recorded in the same manner year after year, assuming of course that there is no special reason to change the method. If this is so, it should be so noted. Similarly, in order to compare the records of one hospital with those of another, it is necessary to maintain a consistency in the accounting records of both hospitals. Consistency and uniformity in accounting principles and procedures between hospitals permit a communication and comparison which is extremely useful, and the *Canadian Hospital Accounting Manual* provides such a uniform system and thereby assists comparisons between all hospitals. We feel that everyone concerned with hospital accounting will find this book profitable and useful.—G. McC.

C.H.A. Assembly Meeting

THE Canadian Hospital Association will hold an Assembly meeting at the Park Plaza Hotel in Toronto, May 23 to 25, 1960. Prior to 1958 the association held meetings only every second year. At the 14th biennial meeting held in conjunction with the Western Canada Institute in Saskatoon in May, 1957, delegates suggested that the Assembly should meet annually, because of the increasing complexity of hospital operation. The Board of Directors was instructed to give the idea serious consideration. As a result, the first "off-year" Assembly meeting was held in Toronto in 1958 and lasted two days. The session was devoted to the business of the national association and to an exchange of information and ideas between member associations and Catholic hospital conferences. At the 15th biennial meeting held in Montreal in May, 1959, the Assembly went on record that the association would henceforth meet on an annual basis.

The Assembly is the governing body of the Canadian Hospital Association. It is made up of a Board of Directors elected by the active members, and official delegates and alternates appointed by the associations and conferences which comprise the active membership of the association. A meeting of the Assembly is not in a strict sense a convention. There are no exhibits; its purposes are to transact association business, to discuss the viewpoints and problems of hospitals, and to formulate policies for both the national association and the member organizations. Discussions are informal and of the conference type.

This year the program committee is planning a three-day Assembly meeting. It will be similar in type to the 1958 meeting; the work of the national association will be reviewed and the association's new office building at 25 Imperial Street will have an official opening. A highlight of the program will be an exchange of information between member associations and conferences on the third day. Whereas in 1958 and 1959 such exchange was limited, for the most part, to discussions of various facets of governmental hospital insurance across Canada, at the 1960 meeting, it is proposed to ask each association to give a half-hour review of its work for member hospitals. Time will be provided for an adequate question and answer period.

Graduate Education in Hospital Administration

a review of 12 years' growth and progress of the University of Toronto's program and its graduates

Kenneth S. McLaren,
Toronto, Ont.

JUNE 1960 will mark the completion of studies for the members of the twelfth class of the two-year graduate course in hospital administration, University of Toronto. When they graduate these 14 senior students, currently serving as administrative residents in general hospitals throughout Canada and the United States, will join a steadily growing body of formally trained personnel employed in a number of administrative capacities in the Canadian and United States health fields.

University education in hospital administration is a relatively recent development, the first graduate program having been established at the University of Chicago in 1934. Following World War II a serious shortage of trained hospital administrative personnel became evident, resulting in the establishment of graduate programs in a number of other universities throughout the continent. At present the number of programs stands at 17 of which two (University of Toronto and University of Montreal) are located in Canada.

After 12 years of successful operation it may be appropriate to review and assess the contribution of the Toronto program to the health field and the progress of its graduates in the field. The graduate course was established in 1947 as a department of the university's school of hygiene under the direction of Dr. G. H. Agnew and through the generous support of the W. K. Kellogg Foundation. The principal aim of the graduate course, as of its sister programs throughout the continent, has been to prepare men and women for the assumption of administrative positions in hospitals and related health agencies. To accomplish this end, it has endeavoured to select those candidates deemed to possess a potential for leadership and to offer them a curriculum containing a balance of administrative knowledge and philosophy, managerial skills and an understanding of the health environment, and so structured as to promote in each candidate a full development of administrative breadth, perspective and technique.

In 1956 the University of Toronto was joined by the University of Montreal in the training of hospital administrative personnel for the Canadian health field. Established in its Ecole de Hygiène, the University of Montreal's Institut Supérieur d'Administration Hospitalière, with Dr. Gérald LaSalle as director, became the first French language program on the continent. The two Canadian programs together with 13 American programs are members of the Association of University Programs in Hospital Administration. Institutional membership in the American Hospital Association is also held by the Canadian programs.

The Candidates

Since its founding, the Toronto program has enrolled a total of 137 candidates, an average of approximately ten per year. Throughout the years, however, class sizes have tended to increase, in keeping with the growth of health facilities and the field generally. Currently the size of each of the junior and senior classes is 14 students. While the classes have increased in size the desire has been to keep them small so that teaching can be done in the seminar setting and more individualized instruction promoted.

As shown in *table 1*, the graduate course has drawn its enrol-

Table 1
Distribution of Graduates according to origin, Administrative Residency Location, and Post-Residency Locations, 1947-59, Inclusive

Region	Number of originations	Number of residency appointments	Number of first appointments	Number of current appointments
Alberta	4	5	2	2
British Columbia	15	7	8	6
Manitoba	4	5	4	6
New Brunswick	2		1	
Newfoundland	1		1	1
Nova Scotia	6		4	4
Ontario	25	55	31	31
Quebec	11	8	11	9
Saskatchewan	15	3	12	10
United States	20	26	28	25
Jamaica	1		1	1
Haiti				1
Costa Rica				1
India				1
Armed Services	5		5	6
Not in field			1	5
Totals	109	109	109	109

The author is an assistant professor of hospital administration, School of Hygiene, University of Toronto.

Table 2

Distribution of Hospital Administration Students according to Educational Background, 1947-60, Inclusive

Undergraduate field*	Number of Students
Agriculture	1
Arts and Science (general and honours)**	54
Business Administration and Commerce	22
Education	1
Medicine	26
Nursing	5
Pharmacy	10
Public Health	1
Social Work	3
Total	123

*As determined by degree(s) held
**In non-administrative fields of study

Table 3

Nearness to and Remoteness from the University of Administrative Residency Appointments, 1948-59, Inclusive

Residency year	Residencies within 100 miles of University		Residencies beyond 100 miles of University	
	No.	%	No.	%
1948-49	1	25	3	75
1949-50	4	36	7	64
1950-51	3	25	9	75
1951-52	5	42	6	58
1952-53	5	42	6	58
1953-54	3	43	4	57
1954-55	6	50	6	50
1955-56	5	50	5	50
1956-57	2	29	5	71
1957-58	7	58	5	42
1958-59	6	60	4	40
1959-60	10	71	4	29
Totals	57	46	66	54

Table 4

Distribution of Administrative Residencies According to Size of Hospitals, 1948-59, Inclusive

Size of hospital (in beds)	Number of Residencies
1000 and over	18
800 to 999	16
600 to 799	23
400 to 599	41
200 to 399	20
Up to 199	2
Total	120*

*11 of the 109 residencies were taken in two hospitals, for instance one consisted of three months in a sanatorium and nine months in a general hospital.

Table 5

Frequency of Participation of Hospitals in the Graduate Course, 1948-59, Inclusive

Frequency of participation	Number of hospitals	Number of residency placements
Once	30	30
Twice	14	28
Three times	4	12
Four times	4	16
Five times	2	10
Six times	2	12
Twelve times	1	12
Totals	57	120*

*109 residencies, 11 of which were divided between two hospitals.

ment from a wide area. From 1947 to 1959 inclusive, nine of the ten Canadian provinces were represented by varying numbers of candidates. Though not indicated in the table, five of the nine hospital geographic regions of the United States provided the 20 candidates tabulated. One candidate is shown to have come to the graduate course from Jamaica and five from the armed services of Canada.

Since hospital administration is studied at the graduate level at the university, the principal admission requirement of candidates is graduation from a recognized college or university. An examination of the information contained in *table 2* reveals a variety of academic backgrounds among the enrollees over the past 12 years. Arts and science graduates with majors or honours in other than administrative or cognate subjects have predominated, accounting for approximately 44 per cent of the total. Graduates in medicine have constituted the second largest group (21 per cent), followed in turn by business administration (including arts majors or honours in administration) and commerce graduates (18 per cent).

Preceptorships and Administrative Residencies

The second or senior year of studies in hospital administration at university has consisted, traditionally, of a full calendar year of administrative residency under the preceptorship of the chief executive officer of a hospital or related health agency. Administrative residencies of the Toronto program have been taken in selected hospitals throughout Canada and the United States as illustrated by the geographic distribution in *table 1*. As shown in the table, hospitals in six Canadian provinces have participated in the program, with hospitals in Ontario providing approximately one-half of the residency positions. Slightly over one-quarter of the residencies were taken in provinces other than Ontario and nearly one-quarter were taken in the United States.

Because the administrative residency is an integral part of the graduate course, responsibility for placement of the students in selected hospitals and supervision of their residency programs has rested with the university through the staff of the department of hospital administration. In many instances, however, the distance of the hospital of residency from the university has rendered continuing supervi-

sion of the senior year difficult. Where a resident is located more than 100 miles from the university, academic exchange and access to library facilities become virtually impossible for him. With respect to this matter it is pertinent to note the changes that have occurred in residency distances since the inception of the graduate course. *Table 3* sets forth the numbers and percentages of the membership of each of the 12 classes according to location within or beyond a 100 mile radius of the university. These data indicate a trend toward increased local placement of the residents throughout the years. Whereas in 1948-49 only one of the four members remained nearby, in the current residency year, 1959-60, ten or 70 per cent of the class are serving residency appointments locally. For the coming residency year, 1960-61, arrangements are being completed to place the entire resident membership within the local vicinity and to implement fully the program of advanced seminars in administrative practice currently being conducted on an experimental basis with the local residents.

Hospitals selected for administrative residencies have been principally general hospitals for the care of the acutely ill; as *table 7* indicates, over 85 per cent of residencies have been served in this type of hospital. Approximately eight per cent of residencies (chiefly for armed services or Veterans' Affairs personnel) have been taken in veterans' hospitals. Small percentages have been taken in children's hospitals and sanatoria, the latter participating for part-years only primarily for students preparing for careers in sanatoria administration.

An examination of *table 4* reveals that hospitals chosen for residencies have been distributed throughout a broad size range. As illustrated in the table the modal size class was reckoned to be 400-599 beds, with a broad scatter of utilization found above and below this class. The actual size range of the participating hospitals was determined to be 117 to 1,580 beds, with lower quartile, median and upper quartile sizes of 420, 560 and 835 beds respectively.

As shown in *table 5* a total of 57 hospitals have participated in the residency program of the graduate course. With the exception of one hospital with a frequency of participation of 12 times, the range of participation frequency was calculated to be from one to six times.

Table 6

Distribution of First and Present Appointments According to Type of Employment, 1949-59, Inclusive

Type of employment	Number of first appointments	Number of present appointments
Allied agency	4	8
Armed Services	5	6
Education and research	3	6*
Government health services	16	9
Hospital administrator	17	47*
Hospital assistant administrator	26	24
Hospital Administrative assistant	32	5
Hospital department head	6	
Not in field		5
Totals	109	109

*One part-time

A review of the frequency of participation of preceptors in the graduate course reveals a range that is not dissimilar; of 70 hospital administrators who have served as preceptors 45 have participated once, 11 twice, six three times, three four times, four five times, and one eight times.

Graduates in the Health Field

While a study of the post-residency appointments of graduates to determine the nature of their beginning employment may lack a measure of reliability due to the temporary nature of some of the appointments (several graduates having remained for varying periods in their hospitals of residency), such an analysis does provide a gross picture of entrances to the field. *Table 6* describes post-residency appointments in terms of eight employment categories. As shown therein, 81 graduates, representing 73 per cent of the total group, were appointed to hospital positions at four executive levels. Of the remaining 28 graduates, five resumed service in the armed forces, 16 assumed administrative positions in hospital divisions of provincial or state departments of health, three were appointed to teaching and/or research positions and four joined allied health agencies such as hospital associations, medical care programs and hospital consulting firms.

The geographic distribution of first appointments is presented in *table 1*. As shown in the table six graduates took employment in the Atlantic provinces whereas nine candidates came from that region. The central provinces are shown, however, to have gained six graduates over the number of their originations, whereas the prairie provinces lost four. The province of British Columbia, in its turn lost seven. A further observation is the coming of 20 candidates from the United States and the first appointment of 28 graduates in that country.

Table 7 reveals that approximately 85 per cent of those graduates taking first appointments in hospitals did so in active general and children's hospitals. Five per cent

Table 7

Distribution of Administrative Residencies, First Appointments, and Present Appointments, According to Type of Hospital, 1948-59, Inclusive

Type of hospital	Number of residencies	Number of first positions	Number of present positions
Active general	95	67	59
Cancer		1	1
Children's	3	2	4
Home for the Aged			1
Orthopaedic		2	1
Psychiatric		1	1
Tuberculosis	2*	4	4
Veterans'	9**	4	5
Totals	109	81	76

*Taken in part in general hospitals
**Five were taken in part in general hospitals

are shown to have begun in each of veterans' and tuberculosis hospitals. The remaining five per cent of appointments were distributed among cancer, psychiatric and orthopaedic hospitals.

The distribution of first appointments among four hospital executive levels as depicted in *table 8* indicates a direct relationship between the numbers employed at the various executive levels and hospital size. Hospitals offering these appointments are shown to have extended through the broad size range of 30 — 2,100 beds. As indicated in *table 9* the modal class size of hopitals employing entrants to the field is 100-199 for administrators and 500 and above for assistant administrators, administrative assitants and department heads.

First appointments accepted in government health services are shown in *table 10* to have occurred most frequently in the province of Saskatchewan, its government having employed ten entrants to the field. One entrant was employed by the governments of each of the provinces of British Columbia, Newfoundland, Nova Scotia and Ontario.

The seven first appointments in the category of allied agencies are shown in *table 11* to have been divided approximately equally among the Canadian Hospital Association, medical care plans and universities.

Current Employment Picture

In respect to the current geographic distribution of the graduates in hospital administration as set forth in *table 1*, appointments are held in nine Canadian provinces, the United States and in four jurisdictions beyond the North American continent. Examination of the data pertaining to particular Canadian areas reveals that whereas nine candidates came from the Atlantic provinces, only five graduates are currently serving in that region. The central provinces are shown, however, to have gained four graduates over their number of candidate-originations. In contrast, the prairie provinces have lost five and the province of British Columbia has lost eight. The number of current appointments in the United States, on the other hand, exceeds the number of candidate-originations in that country by five.

The distribution of graduates according to the types of current positions held is illustrated in *table 6*. Seventy-six graduates, or approximately 70 per cent, are found to be employed at three executive levels in hospitals. Of this number over 60 per cent hold the position of administrator, approximately 30 per cent are assistant administrators and roughly seven per cent are administrative assistants. Thirty-three graduates, or 31 per cent of the total, are shown to be employed in non-hospital positions. Of this number nearly one-quarter are serving in government health services, another quarter in the allied health agencies, and somewhat smaller groups in education and research and in the armed services. Less than five per cent of the graduates are shown to have left the health field.

According to *table 7* over 75 per cent of the graduates serving as hospital executives are employed in active general hospitals. Approximately 20 per cent are distributed equally among children's, tuberculosis and veterans' hospitals. Five per cent are shown to be employed in four other types of hospitals.

Examination of the sizes of hospitals employing graduates as described in *table 8* indicates broad size ranges for each of the three executive levels at which employment occurs, and in addition, an inverse relationship between the numbers employed at the executive levels and the size of hospitals. In

(continued on page 72)

Table 8

Medians and Size Ranges of Hospitals Offering First and Present Appointments to Graduates, According to Type of Appointment, 1949-59, Inclusive

Type of position	First Appointment			Present appointment		
	No.	Median hospital size	Hospital size range	No.	Median hospital size	Hospital size range
Administrator	17	124	30 - 310	47	175	30 - 890
Assistant administrator	26	359	31 - 1580	24	370	62 - 1580
Administrative assistant	32	515	240 - 2127	5	410	300 - 890
Department head	6	415	240 - 930			
Totals	81	420	30 - 2127	76	300	30 - 1580

Table 9

Distribution of Graduates in First and Present Hospital Positions, According to Size of Hospital, 1949-59, Inclusive

Hospital size and classes	First position			Present position		
	Administrator	Assistant Administrator	Administrative assistant and department head	Administrator	Assistant Administrator	Administrative assistant
500 & above		10	19	5	8	4
300 - 499	2	7	15	12	4	1
200 - 299	2	3	4	6	7	
100 - 199	6	4		12	4	
50 - 99	5	1		10	1	
Up to 50	2	1		2		
Totals	17	26	38	47	24	5

Educational Activities

Lawrence L. Wilson
Toronto, Ont.

Despite careful planning, the success of a summer session is dependent largely upon the very active participation of the faculty, not only during lectures but, also, informally in the "off" hours. Last summer nearly 50 people presented 80 lectures and took part in more than 145 seminars and problem clinics. We extend to them our sincere thanks for their valuable time and for the way they stimulated interest and assisted the students whenever possible. We should like especially to acknowledge the assistance of Raymond Sloan of New York; Stanley W. Martin, our president; A. H. Westbury of the Montreal General Hospital; Edward Turner of the Stevens Companies of Canada; and Dr. Ernest Boettcher, St. Joseph's Hospital, Victoria. for their splendid lectures. We appreciate the help given by Ghislaine Majeau, now of Montreal, with problem clinics and seminars and also the assistance of other members of our association staff. It was during these clinics and seminars that the real teaching was done because they gave opportunity for discussion and free exchange of ideas.

Appraisal

Again in 1959 the province of Ontario had the largest number of graduates, 134; while the four western provinces had the next largest group. The class enrolled in August, 1959, shows an increase of ten administrators and assistant administrators over the number in those positions in the 1958-59 class; while the number of Sisters dropped by almost half.

The trend is toward a younger age group; and it may be expected that during the next few years we shall see fewer of the group from 41 to 50 years and over, and a very definite increase in the 31 to 40 years group. Also apparent is an improvement in the academic status of the people accepted for this training. There are now an appreciably greater number who have completed senior matriculation.

The very fine motivation and interest present in the past continues to be reflected in the quality of work submitted by the present students. In a questionnaire circulated at the end of the last summer session it was found that the average time spent in the reading and preparation of lesson material accounted for 11.3 hours each week. When it is realized that these students, practically all of whom lead very busy lives, are willing and anxious to devote so much of their time to the course in order to improve their understanding of hospital matters, the full impact of what the course is accomplishing becomes apparent.

2. *Institutes and Workshops*

The interest of Canadian hospitals in continuing education was definitely established last year when the association sponsored six workshops in the western provinces. Last month and currently, the association is sponsoring four five-day laundry institutes in Manitoba, Saskatchewan, Alberta and British Columbia. These sessions are designed to meet the needs of the small and medium-sized hospitals in these areas. The program includes material on personnel, plant equipment and layout, washroom supplies, washroom formulae and, as well, lectures on linen and its control and distribution.

During this year our association will co-sponsor, with the Canadian Society of Laboratory Technologists, at least one one-week program designed to assist chief laboratory technologists who are responsible for training programs in hospital schools. Staff members will be drawn from the Department of Education of the University of Toronto and from its division of adult education. If this first pilot workshop proves successful, it is planned to offer a similar program in various centres throughout the country. It is hoped that the success of such workshops will pave the

1. *Extension course in hospital organization and management*

DURING its seven years of operation ending with the 1959 summer session this course has awarded 164 certificates to men and women in the hospital field. This total includes 17 from other countries. In the eighth year of the program, which began in mid-August of last year, there are 160 students, 82 in the first year and 78 in the second.

In the spring of 1959 the Selection Committee considered over 160 applications and, following the recommendation made by the Committee on Education at its last meeting, reduced the number of acceptances from a record high of 93 for the first year to the present number. When we were preparing the budget for 1960, it became apparent that the cost of conducting the course has increased. Therefore, rather than raise the $175.00 tuition fee, it was recommended that the quota of students be again increased to offset the rising cost. This was approved by the Board of Directors at the December meeting. By maintaining a minimum of 90 students in any given year, the cost problem can be overcome.

During the past academic year ten lessons were completely rewritten; and this year the four lessons which embody material drawn from the *Canadian Hospital Accounting Manual* and the lesson on radiology are to be revised. In addition, the assignments for several lessons have been rewritten.

During each of the past eight years, at least 25 people in the hospital field have acted as markers of assignments; and the comments they have written on the papers have been of major importance in guiding the students. Although we have acknowledged their endeavours in reports of this nature, it is hoped that before the end of this academic year we may be able to offer them a tangible expression of our gratitude for the time they have so unselfishly given to ensure the success and improvement of the course.

Each year the summer program is designed not only to amplify but to promote discussion of material covered during the winter lessons. From this point of view, it was felt that the 1959 summer session at the University of Toronto was very successful; even though it demanded much from both the students and the faculty. The four-week program was attended by a total of 145 students from both years.

way for other jointly sponsored institutes in the paramedical field.

3. *Extension Course for Medical Record Librarians*

The sixth group in the extension course for training medical record librarians commenced their studies in August, 1958. Of this class, three were unable to keep up with the year's work and requested permission to transfer to the 1959 class, two withdrew from the course, and five failed the examination on the home-study portion of the work. Those who continued, 35, successfully completed their intramural sessions.

In the second year, 35 students started. One requested a transfer to the 1959 group and three did not pass the winter session examination. Those remaining in the class, 31, proceeded to their intramural sessions, as did two students of former years who had been unable to attend previously. One student failed leaving the number who graduated at 32.

The seventh class, with 52 students—49 new applicants and three transfers from previous years—began in August, 1959. Five have since withdrawn, leaving 47 now enrolled.

A new edition of the *Textbook of Anatomy and Physiology* used in the course was received in June, 1959. This made it necessary to change a number of lessons and assignments based on the textbook and, in addition, complicated the matter of student book orders, some of which had already been filled. Doris McPherson, then supervisor of the course, was able to complete the revision for only the first year, but revised a number of assignments for both years.

During the year 14 markers reviewed and graded approximately 1,200 assignments submitted by students of both years; and the registered medical record librarians of 22 approved hospitals across the country accepted students during the summer months. They provided instruction and supervision in the practical work designated for intramural session experience. The debt to all librarians who, in addition to the management of busy departments, shared, and are continuing to share, their knowledge and experience with extension course students is gratefully acknowledged.

Last year it was possible to provide enough centres to permit adequate scheduling of student time. The following is a list, by province, of the hospitals which held intramural sessions:

British Columbia: Royal Columbian Hospital, New Westminster; St. Paul's Hospital, Vancouver; and St. Joseph's Hospital, Victoria.

Alberta: Calgary General Hospital, Calgary; Edmonton General Hospital, Edmonton; and University of Alberta Hospital, Edmonton.

Saskatchewan: University Hospital, Saskatoon; and Regina Grey Nuns' Hospital, Regina.

Manitoba: St. Boniface Hospital, St. Boniface; and Winnipeg General Hospital, Winnipeg.

Ontario: St. Michael's Hospital; Queensway General Hospital; Northwestern General Hospital; Toronto General Hospital; St. Joseph's Hospital; and Humber Memorial Hospital, all in Toronto; as well as Hôtel Dieu Hospital, Kingston; and Ottawa General Hospital, Ottawa.

Quebec: Hôtel Dieu, Montreal.

New Brunswick: Moncton General Hospital, Moncton; and St. Joseph's Hospital, Saint John.

Nova Scotia: Halifax Infirmary, Halifax.

With the inclusion of last year's successful second-year group, there are 147 graduates of the extension course.

At the request of the Canadian Association of Medical Record Librarians, this association made a survey of record librarians in Canadian hospitals last autumn. Some 507 questionnaires were mailed and replies were received from 310 institutions. Of these, 125 stated that they had sufficient medical records staff, 165 reported a shortage, and 119 indicated that they had employees whom they would like to sponsor for the extension course during the next three-year period. It was interesting to note that the reporting hospitals showed there were only 78 registered record librarians in charge of departments as compared with 32 extension course graduates. In addition, 35 institutions indicated that the record librarian in charge was at that time enrolled in the extension course. The survey also showed that 122 librarians in charge of departments did not have any formal training whatsoever.

This survey thus indicates that there is still a very large untapped pool of potential students for the extension course.

With the resignation of Doris McPherson in August 1959, the course was for a time without a program supervisor. However, Mrs. Barbara Johnson, a graduate of the school at St. Michael's Hospital in Toronto, has been appointed consultant to the course and assumed her duties as of January.

Administration of the Course

Under the original terms of an agreement with the W. K. Kellogg Foundation, it was agreed that the Canadian Hospital Council was to sponsor, in co-operation with the Canadian Association of Medical Record Librarians, an extension course for the training of personnel to serve as medical record librarians. The Canadian Hospital Council, now "association", was charged with the responsibility of organizing, preparing, and putting into operation this program and, once in operation, it was to be managed and directed by the Canadian Hospital Council, which made facilities and personnel available. To expedite the terms of the agreement, a joint committee was established, with representatives from the Canadian Hospital Council and the Canadian Association of Medical Record Librarians. In the years following the Joint Committee continued to function and, as an adjunct, a smaller unit, a selection committee, made up of members of the Joint Committee, examined the admissibility of students for the course and determined whether or not an individual should continue in the event of problems arising.

During the past few years the administrative section has encountered difficulties because of misunderstanding or misinterpretation of the responsibilities and relationships between this section and the Joint Committee. At the present time, because we do not have definite terms of reference for the committee and because there are no well defined lines of authority in the relationship between the two associations, increasingly more serious problems are being faced. The Canadian Hospital Association has, during the past two years, underwritten the operating deficit which arose after termination of the grant from the W. K. Kellogg Foundation.

At the December, 1959, meeting of the board of directors of the Canadian Hospital Association, consideration was asked for the formation of a committee to study the future of the extension course for

(continued on page 102)

NEW INTERNS' RESIDENCE

OTTAWA GENERAL HOSPITAL

DUE to expansion at the Ottawa General Hospital the number of interns increased so that their accommodation became a real housing problem. They had to occupy several neighbouring houses until circumstances would permit the erection of a building for their exclusive use. This building is now a reality.

The official opening of the new interns' residence took place on January 19th and the blessing was provided over by the Most Reverend Marie Joseph Lemieux, O.P., Archbishop of Ottawa. The traditional ribbon was cut by His Worship, Mr. George Nelms, Mayor of Ottawa.

The three-storey building, designed by architect Auguste Martineau and built by J. P. Morin Limited, stands at the south-east corner of Parent and Bruyere Streets, the front measuring 138 feet along Parent, with a depth of 27 feet on Bruyere. It is built of red and cream brick and the materials used in the construction make it entirely fireproof. Outer walls and floors are of reinforced concrete, the exterior walls of glazed and plain brick; the floors in the corridors and stairs are terrazzo finished, with vinyl floor-tiles used in the rest of the building. The heating of the residence is furnished by the central power plant of the hospital which itself has been recently completed.

The cost of the building, completely furnished, amounts to $263,000. The federal and provincial grants, respectively $750 and $2,000 per bed, leave a margin of $114,500 which the hospital has to meet out of its own funds.

The residence can accommodate 54 interns. Each bedroom is provided with running water, a bed with inner spring, a wardrobe to which are attached a dresser and desk, a study-lamp, a bed-light, an easy chair, and a telephone connected with the central exchange of the hospital. Any intern can thus be called within a minute or so. As well there is a commodious tile-finished bathroom on each floor with showers and baths.

The ground floor contains a lounge and a large recreation room. Provided with folding doors, the latter can be partly transformed into a reading room for those interns who look for seclusion and quietness.

Sober and comfortable at the same time, the furniture of the lounge comprises sofas, settees and high-back lounge chairs. Heavy plastic coverings are used over foam-rubber to give comfort, yet easy maintenance. All framing is steel in brushed chrome finish. Special attention has been given to an effective choice of colours. The bright furniture coverings are softened by restful blue-grey and green walls throughout. In the bedrooms, the common unit of wardrobe, drawer section and desk lies on a metal base, while tops and drawer fronts are covered in a walnut-grained solid plastic for maximum durability. All metal portions are enamelled in bright lacquers which tie in with the colour schemes chosen for the walls and draperies.

The corner-stone, with pertinent documents enclosed, has been laid in the centre of the first brick panel to the left of the main entrance. ■

Left: Lounge, Right: Bedroom

WHY A LIBRARY ?

"There is no frigate like a book to take us lands away".

(Emily Dickinson)

Sister Mary James, SCIC,
St. Vincent's Hospital,
Vancouver, B.C.

HISTORICAL data records that libraries of one kind or another existed as far back as some 4,000 years ago. Aristotle is believed to have been the first person to collect a library. Many of his own works were written on papyrus, the use of which continued among the Greeks and Romans to the 4th century A.D., when parchment books came into vogue. The religious library is said to be surely the "dean of all", with the roots of its genealogical tree in the collection of temple records, inscribed on clay tablets dated at approximately 2000 B.C. In our own day the need for adequate library facilities is generally recognized—but here is the paradox: in a recent survey it was brought out that one-half of the voluntary hospitals were without a patients' library, and one-third had no medical library!

This paper is about a reading service for our patients; nevertheless, it is not out of place to remark that the new requirements of the Commission on Accreditation have stimulated administrators and medical staffs in favor of the advantages of a medical library. Directors of nursing have long seen the necessity of a useable collection of books for their students. It will not be surprising if soon the Commission includes evaluation of the patients' library service in accreditation surveys. The library cannot mend broken bones, remove diseased organs, or correct other physical deficiencies, but isn't it just as important to mend and nurture minds and morale?

Let us consider briefly the pros and cons of an *integrated* library system. In 1947, in a Manual for Hospital Libraries edited by C. E. A. Bidwell (London, Eng., Lib. Assoc.), integrated libraries were predicted. Integration of medical and nursing libraries improves service, increases economy, and utilizes space more effectively. Harper Hospital in Detroit has had a successful integrated three-library system for several years, however, some reservations should be expressed, namely, the differences in function among the patients' and medical or nursing school libraries, and the size and type of hospital. (The reader is aware that patients should not have access to the professional collection).

Planning for effective library service requires attention to some basic principles: (1) the necessity for full recognition by boards and administrators of the growing importance of such service to the sick, (2) need for assurance of adequate financing, (3) special requirements of hospitals of different sizes and types of care, (4) scope of training programs for clerks, volunteers, nurses, therapists, and other personnel, (5) availability of library service from other sources in the community, (6) importance of library facilities in strengthened programs of hospital accreditation.

The administrator working within a restricted budget, and in circumstances (e.g., under a health insurance plan) where a reading service to patients is not deemed a "bona fide" inclusion in the annual budget, will not too readily give impetus or approval to such a function. Medical and nursing libraries are costly to organize, develop, and supervise; however, an excellent patients' library is possible, but, almost entirely on book donations and volunteer services. Cash donations are always useful too.

Whether the institution cares for short- or long-term patients, surgical, medical, maternity, or the mentally ill, will have a bearing on the library set-up. In attaining its objective, the patients' library coordinates with all departments of the hospital, and shares with them the responsibility of social adjustment and vocational education of the patient. It promotes reading as a satisfying experience both in and out of the hospital. Well-organized within itself, and being delegated sufficient authority by a wise and understanding administrator, it can contribute tremendously to the great group-objective of all in the hospital organization — "the patient"—and, at the same time, be a vital influence for good public relations.

Public relations are just as essential in regard to library service as any other hospital department. Back in 1878 Melvil Dewey wrote a series of articles about library

systems. "There is nothing in library economy that influences the opinions of borrowers so much as the system of issuing, charging, and checking in books." Efficient service, which produces good public relations, should predominate, and one way to achieve this is the elimination of unnecessary procedures in record keeping. A great deal of effort can be wasted in doing some things which do not need to be done at all. What can be called the "what", "when", and "who" files can be utilized both in respect to books and to borrowers. A "what-about" or "subject index" file is a useful one to include also. Numbering and classification can be very simple, and often because of this very simplicity, more useful and practical.

Some general norms in regard to library personnel are these: all should have a fairly wide knowledge of books and of people, and in the latter respect, a proper understanding of and approach to people who are ill or convalescing. (There's a difference!) In a paper given in Paris in 1936, Mrs. M. E. Roberts, then secretary of the International Guild of Hospital Librarians, summed up very well the qualifications of a hospital librarian when she said: "To a certain degree this work is a vocation—it cannot be undertaken successfully without an instinctive understanding of human nature, tact, cheerfulness, and a love of reading. The qualities that can be *learned* are: method, punctuality, and a general knowledge of elementary library technique and hospital etiquette. The need for the library to be recognized as a unit and not merely as an outside social service must be stressed. The head librarian, therefore, requires the extra qualifications of ability to organize, to understand publicity, to control and stimulate team work, and to fit the right workers into those parts of the library service for which they are best suited."

Dr. Carl Sawyer of Sawyer Sanatorium has written a paper, "Psychology of the Sick", which proves very useful in orientation of volunteers. A good basic list of routine daily procedures for volunteers will be found in the October, 1955, issue of *Hospitals*. The following are basic and fundamental check-points in recruiting or accepting volunteers: (a) a cultural sense of values, (b) a genuine liking for and understanding of people, (c) initiative and imagination to recognize different qualities in different people, (d) ability to meet emergencies with calmness and good judgment, (e) an attractive appearance resulting from good grooming, (f) sufficient physical strength to push the book-cart(!), and (g) must read current reviews and study current bibliographies in order to make intelligent selections and recommendations. Philomena Kerwin has said, "Of all the departments in a hospital which provide an ideal setting for volunteers, one of the most significant is the hospital library". In order to equip herself better to recommend books which the patient will either enjoy, or find helpful, the librarian must learn the background, interests, hobbies, temperament, and mental capacity of each, and with a sincere and simple approach, win their confidence. Some have just never had the opportunity or the incentive to have access to books before.

While providing reading "to pass the time" is an obvious purpose, the real aim is to introduce books that stimulate interests, broaden horizons, bring fresh contacts, thus helping patients to create a happier mental attitude that will counteract apathy and discouragement. It is acknowledged that properly selected reading matter is of great therapeutic value.

Naturally, the librarian with a degree in Library Science has wonderful advantages, but she can also do a splendid job without this if she possesses the seven qualities listed plus a knowledge of typing and filing! Cheerfulness and zest are just as important in the library as in any other department. As you read on you will probably surmise, and rightly so, that the writer has some very definite views on the project under consideration, (which are not entirely theoretical). I must confess that up until three years ago appreciation on my part was not too enthusiastic, although I did acknowledge that reading service did have a certain recognizable place in the patient-care program. Since then, because of my direct association with patients' and medical libraries, the generosity and personal qualities of selected volunteers, the gratitude and joy of patients and staff, and the "go-ahead" of those in authority, I can only endeavor now to be sufficiently grateful for what these three years have done for me—as well as for what I have seen library service do for others. Often the prayer of the old Sioux Indian comes to mind: "Great Spirit, help me never to judge another until I have walked two weeks in his moccasins!"

Before concluding our assessment of library personnel, let us consider another important responsibility—advertising the library—this is a "first" after acquiring a basic supply of books. It is not too amazing that often many do not know the library exists, or think it is "only for the patients". There are several ways of publicizing the library within its hospital environment, and one must adopt the method best suited to one's own particular milieu. How about neat, attractive, colorful little memos circulated through the courtesy of the payroll office, coffee shop, admitting office? These can show the hours, the dues on rentals by staff, they can list at intervals three or more "new arrivals", with the authors' names. (I have specified "rentals by staff", because this is one valuable service we can render the *patient* without charge, and the income on rentals constitutes part of a useful little fund for incidentals.)

What books? How many? How many in each classification? The best way to categorize books? Does this depend on the size and type of institution? Space is always a factor it seems—and so we stress "quality rather than quantity"—but the word "quality" has to be understood in its proper sense. Organize well, but do not over-organize.

Man, an integrated human being, has mind, soul, and body—and hospital people recognize that all three components of their patient must be cared for if our program is to be successful and complete. Surgical care, medications, treatments, provision of a chaplain, psychological and psychiatric care when indicated—all these are vital—but so is diet! We are agreed that the trays sent in to our patients must carry nourishing, appetizing food, attractively served, and suited to individual needs. Let us apply this to reading, so aptly called "food for the mind"—the books selected by the patient or recommended to him have to be of good standard; they should be neatly covered with serviceable, washable plastic; it is a means of adding to the personality of a book to let it retain its jacket if this has eye-appeal. The volumes circulated must interest, inspire, or

encourage; amusing books will often arouse a dormant sense of humour, biographies of those who have surmounted tremendous physical handicaps or other obstacles will effect a diminution in self-pity. There are books in which the charcaters learn to adjust to situations or environments to which they are not naturally adapted, to better their own lives or the lives of those dependent on them, either in a moral, economic, or social way. This helps the patient, when he reads about others having problems similar to his own. There are many books, too, which increase faith in God and in one's fellowmen. Stock mostly medium-sized books, having large, clear print whenever possible. For a two-hundred bed, acute care, hospital, it will be found that 1,000 to 1,500 volumes are sufficient, the fiction quota being the largest, and comprising about one-third of the total. Other categories are biographies, humour, history, travel, religious books, classics, the fine arts, and hobbies; (the reference section in a small library will include the fine arts).

It is most inadvisable to give the over-stimulated or over-anxious patient books which will increase sensitivities. Do not give the depressed, discouraged, melancholic individual reading that will simply send him further into the doldrums. No patient should be urged to read any book, title or author to which he has an aversion. In the Catholic hospital, it is felt that the library should also offer, to those who do not possess it, knowledge of Catholic literature as well as the Catholic point of view on all literature. Any book in this section is loaned on request, no questions asked.

Regardless of the fame or excellence (or notoriety) of any author, it is the duty and the kind task of the volunteer to assist the patient in making a choice with discretion. A diabetic can at times be unreasonable and ask for food that will not contribute to his improvement—so also in the matter of this "food for the mind".

It is an excellent idea in this day and age to build up a moderate section in various languages, with the inclusion of two or three copies on "How to Learn English". The better standard "who-done-its" in paper backs are good, as patients often haven't the strength to hold a heavier volume. The various digests, and preferred quality magazines are good to have for distribution, even if they are not current issues; "Westerns" are always popular. To a non-reader, or one who reads only magazines, a book is a mental hazard to be avoided—if good standard reading material is presented through the paper-back medium, one often finds that many become interested, and unconsciously become book readers.

Offering a low-grade novel, or off-color magazine, on the other hand, to a sick person who is more or less entirely dependent on others for the time being, could be compared to putting before a starving man a dish of rotten meat, and a cup of putrid water to assuage his thirst. Certain works of certain writers, while suitable to mature liberal arts college students, studying under guidance, are not adaptable to patients' reading service projects. It is essential that the reviewers be mature and well-balanced persons.

If a book evidences the aim of arousing indecent interest in evil, it is most unsuitable. For instance, a recent "best-seller" comprises 900 distasteful pages in which the lack of moral standards is dramatized with a wealth of slyly insinuated physical details. Compare some of these with the new thriller "Mrs. Christopher", by Elizabeth Myers—the reader will see the difference.

Books written with a genuine sense of humor are most necessary in a library for the sick. The great Thomas Aquinas wrote, "Pleasure is necessary for a truly human life", and goes on to say, "He who abhors pleasures because they are pleasurable is either boorish or ungracious". But St. Thomas also says, "Perfect enjoyment demands intelligence".

Books often form the basis of friendships; discussing books and authors with the librarian may also give a patient an opportunity to give expression to bottled-up feelings. Books chosen with a particular patient in mind satisfy his need for personal attention. I am reminded of the little anecdote, which you will also recall, of the shy young man who did not know how to select the book he wanted, and was not offered any assistance—he finally went home and settled down with a volume entitled HOW-to-HUG, only to find that he had before him a section of an encyclopedia! One of the great values of our work as librarians is that of the concept of the "individual approach". The patient may not always wish a book when the volunteer approaches with the book-cart; however, in the majority of cases, the greatest be[ne]fit of the cart is the arrival of [ne]w people, visitors who are interes[t]ed in the patient, ready to talk ab[o]ut books or other subjects which [t]he patient may introduce (barring [t]he medical of course). Those wh[o] do not read the books may bec[o]me interested in the authors, or [s]eek the books later in bookstor[e] or lending library. Thus many l[e]arn for themselves that a life wit[h]out reading, as a life without musi[c] is most incomplete and lacking [m]uch beauty and enjoyment. If they [w]out reach out for it, it has been pl[a]ced by Divine Providence literall[y] at their fingertips.

May I repeat—quantity is n[o]t as important as quality, balance, [a]nd utility. Books must be used, not catalogued and shelved. The [g]ood library is not a museum of an[c]ient tomes, nor a place of housekee[p]ing beauty, but a warm, friendly se[c]tion of the hospital, a fascinating and interesting place. Here pat[i]ents and staff can be assured of a fine and varied collection of reading matter to suit their need or mood, and cordial and courteous help on the part of the librarian and volunteers. There are four considerations in attaining this ideal: (a) quality of the books, (b) their diversity in keeping with maintenance of good standards, (c) the person who takes them to the patient, and (d) the needs of the individual patient.

I agree with the principle that reading pleasure is basically the pleasure we get from contact with humanity in all sorts of situations. If the librarian can tactfully urge, stimulate, or suggest the "right book to the right person at the right moment" the reader will be on the way to making real for himself what books can do. Books provide fun-entertainment, but most great books, good books, do much more—they not only give entertainment but a true rational pleasure.

A reading service for the various age groups included in a children's library is just as important as a library for adults (and in some instances, more vital). I have always been under the impression that here was one nursing unit which would include such a service, and was somewhat astonished to learn that of 6,192 institutions questioned in a survey in 1951, only 559 (or 1%) had any kind of educational or occupational therapy program for hospitalized children. There has been, gratifyingly, a growing and widespread interest in

(concluded on page 86)

A new training course for

Secretary Managers

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In 1954, at the Saskatchewan Hospital Association meeting, it was decided that an educational program for administrators of small hospitals was necessary. Administrators or secretary managers of small hospitals are often not able to avail themselves of university education in hospital management, nor of the complete extension course in hospital organization and management offered by the Canadian Hospital Association. Likewise, these courses do not directly meet the practical needs of the individual administering a tiny organization. The S.H.A. discussed the development of this course with officials of the Canadian Hospital Association, the W. K. Kellogg Foundation, the Department of Public Health for Saskatchewan and the University of Saskatchewan. As a result of these various negotiations, the University of Saskatchewan, with generous financial assistance from the W. K. Kellogg Foundation and with advice and assistance of officials from the S.H.A. and the Department of Public Health, will offer this course for the first time in the fall of 1960.

The Saskatchewan program is under the general direction of Dr. T. H. McLeod, Dean of Commerce at the University of Saskatchewan. The course supervisor, Mr. C. A. Meilicke, began his duties on July 1st 1959. Mr. Meilicke is a graduate in commerce from the University of Saskatchewan and in hospital administration from the University of Toronto. He has also been appointed as an instructor in the College of Commerce at the University of Saskatchewan and these duties will run concurrently with his duties in developing the course. Work on the curriculum for the course and the method of course operation is well under way. A curriculum committee has laid out the proposed course of studies and an advisory board, with representation from the Saskatchewan Hospital Association, the Department of Public Health and the University, has begun its work.

While it does not exclude administrators of larger hospitals, it is anticipated that the course will be taken by those in smaller institutions, primarily by administrators from hospitals in Saskatchewan, although it will be available to administrators from hospitals in other provinces. The course will extend over a two-year period with twenty-six lessons in each of the two years. During each year, lessons will be sent out at approximately weekly intervals over a six-month period.

In order to be sure that the course will be as practical as possible, the opinions of administrators throughout the province have been sought. Thus, for example, there will be considerable emphasis on bookkeeping and accounting, which is one of the main problems for administrators in smaller institutions.

During each year of correspondence work, lesson material will be sent out with assignments of questions which the administrator will complete and return for marking. As soon as the questions have been marked, they will be returned to the student so that he will know his level of accomplishment. During the early summer, following each year of the course, a two-week seminar will be held in a central location, probably on the university campus. At this time, the students will live in and attend lectures and seminar discussions. It is also planned that during the year, when correspondence lessons are going on, there will be one or two institutes developed so that current lesson material may be expanded upon and questions arising from the students may be dealt with.

Fees for the course will probably be set at $125.00 per year. It is felt that fees must serve as the major source of support for the course once financial backing from the Kellogg Foundation is withdrawn. At the same time, the fee must be within the financial reach of the student. It is also felt that most hospital boards should be interested in having their administrative officer take the course and therefore would be willing to offer at least partial financial assistance.

Educational requirements for students have been set. It is agreed that applicants must have at least a grade 12 education in order to take the course. However, in order to accommodate all administrative officers who at present are occupying positions in hospitals, it has been agreed by the advisory board that special provision be made. Hospital administrators, secretary managers and other senior administrative officers who are occupying their positions at the time the course is begun will be eligible, irrespective of their educational level. December 31st, 1960, has been set as the cut-off date. After this time, the individual must have completed his grade 12 education if he wishes to avail himself of this educational opportunity.

Lest the educational qualifications be thought rather high, some comment might be in order on this point. *First*, the educational standard of our community has been rising steadily and more and more young people are completing their high school education. *Second*, if hospital administration is to achieve its rightful place as a professional activity, we must encourage higher standards of education. *Third*, those who at present hold positions in the administrative field and who have lower qualifications are not excluded by virtue of the cut-off date in December, 1960. *Fourth*, replies to the survey made of Saskatchewan secretary managers indicated that, of the 70 replying, 56 per cent had grade 12 or better; 19 per cent had grade 11 and only 25 per cent had grade 10 or less.

(concluded on page 96)

From an address presented to administrators and secretary managers at the 16th annual convention of the Associated Hospitals of Alberta, October 28, 1959.

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Care of the Mentally Ill in Ontario

History of Treatment

The following four articles on Mental Health complete the symposium begun in the February issue.

Part 2

B. H. McNeel, M.D.,
and
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Treatment

It is appropriate that such a large part of this paper should be taken up with a description of the accommodation provided for housing the mentally disordered since for many years the chief expectation of the asylums and hospitals was that they should keep the inmate or the patient safe. In spite of this low level of therapeutic expectation, some of the early institutions provided activity programs which we envy today, and put a good deal of emphasis on the importance of staff attitudes, and the general atmosphere of the institutional community. The changes in terms during the early part of this century — from "asylum" to "hospital", from "lunacy" to "insanity" to "mental illness", from "guard" to "attendant" to "nurse"—reflect a greater recognition of mental disorder as illness requiring medical treatment. As a result of this shift in emphasis and of medical advances generally, a great variety of physical methods and pharmacological agents were employed and eventually discarded one after another. Apart from the earlier antiluetic treatment, the greatest advance in physical treatment began with the introduction of insulin coma treatment in the late thirties, and was accelerated by the use of prolonged narcosis, electroplexy, psychosurgery, and more recently by the phenomenal development and widespread use of psychotropic drugs. It is interesting that along with the development of more effective physical methods of treatment there has been an increased use of psychological methods in formal psychotherapy, both for individuals and groups.

The past ten years have seen a growing awareness of the therapeutic significance of interpersonal relations and social interaction in the hospital community. The hospital has been described as a "therapeutic community" in which all procedures and activities have a relationship to the therapeutic goal. Activity therapies are receiving a new emphasis, not just as a means of keeping the patient busy, but as media through which psychotherapeutic influences are made effective.

Within the past five years, following the example set by a number of hospitals in England, an "open door" program has been gradually developing. Freedom for hospital patients is not entirely a new idea as, for many years, most mental hospitals have had a good many privileged patients and perhaps an open ward or two. However, in the early part of the twentieth century the chief preoccupation of the public and the hospital staff seems to have been with the secure custody of patients. The reversal of this trend involves no small change in attitude, both of the public and the staff. It has become apparent that greater freedom for patients is an important element in a program designed to develop greater responsibility, self-reliance and self-management. Also, the reduction of the custodial duties of staff permits greater attention to therapeutic efforts. Along with the "open door" as a symbol of freedom a movement to reduce security measures of other kinds, *e.g.* barred windows, heavy institutional furniture, recessed lights, et cetera, is taking place. These changes are not being made with any expectation that security measures can be completely abandoned, but as a practical recognition of the fact that the majority of patients do not require these mechanical substitutes for adequate supervision and should not be subjected to them because of the few who do.

Training

Almost from the beginning the mental hospitals in university centres have been associated with the medical schools in undergraduate medical education. Frequently, the superintendent of the hospital was the professor of psychiatry at the university. Dr. C. K. Clarke, in Toronto in the early 190's, was successively superintendent of the Ontario Hospital, Toronto, and superintendent of the Toronto G[illegible]-

(continued on page 106)

Dr. McNeel is chief of the Mental Health Division, Department of Health. Dr. Lewis is assistant director, Ontario Hospitals, in the same department.

Legislation and Mental Illness

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IT IS LIKELY that some of the problems which arise in connection with mental illness will require legislation for their solution and there may not be general agreement about the solution. It is intended at this time merely to state the problem and not to attempt a solution.

One of the unsolved questions is the treatment of the chronic alcoholic. Many an alcoholic ruins his health and his fortune and causes hardship and distress for his family. So long as he refuses help, there may be nothing that anyone can do to remedy the situation. A possible solution is the enactment of legislation whereby a magistrate may commit an alcoholic to hospital, with detention for treatment. A mental hospital is not the best place for the treatment of alcoholic patients. An alcoholic patient does not believe he is mentally ill. He is likely to resent being in a mental hospital. An adequate arrangement would require a special hospital for the compulsory treatment of alcoholics.

Another group who present unsolved problems are the so-called "psychopathic personalities." This group is well known to psychiatrists. A psychopath (to use the abbreviated term) is of normal intelligence and does not display the usual symptoms of mental illness. He commits anti-social acts, sometimes criminal. There is a repetitive character to these acts and he does not profit by experience.

The British Mental Health Act, 1959, contains a definition:

4. (4) In this Act "psycopathic disorder" means a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment.

The British Act contains a procedure for compulsory admission to mental hospital in some cases of psychopathic disorder. It is doubtful that Canadian psychiatrists would be unanimous as to the best solution. At the present time, some psychopaths go to jail, some go to mental hospital, and some are at liberty. The whole question of psychiatric treatment as an alternative to imprisonment is undergoing research and development.

The new British Act authorizes a judge to sentence a convicted person to mental hospital instead of jail for many offences. This should stimulate much research and development.

There are beginnings in Canada. At the Toronto Psychiatric Hospital there are both in-patient and out-patient facilities, providing diagnostic and treatment services for court cases. Mental hospitals and clinics provide some services for courts. Penal institutions have some treatment facilities. As experience is gained, it is likely that the use of psychiatric treatment will be greatly expanded.

The sex offender is a particular example of the use of psychiatric facilities in criminal cases. Evidence is accumulating that the results are of sufficient value to warrant increasing use of such facilities.

In Canada, the report of the Royal Commission on the Criminal Law Relating to Criminal Sexual Psychopaths recommended (page 130):

15. The Government of Canada, through special grants to universities and otherwise, develop special research schemes to determine the causes of sexual abnormality and improve methods of treatment.

16. Special clinics be set up in cooperation with the courts and penal institutions, to which a person found guilty of any sexual offence may be required to report for study and treatment.

Another problem that arises from time to time is the person who is desirous of terminating marriage on the ground of mental illness. In our jurisprudence, mental illness is not a ground for dissolution of marriage unless (a) the mentally ill spouse was mentally ill at the time of the marriage and hence incapable of appreciating the marital contract; or (b) as a result of mental illness, the mentally ill spouse is incapable of consummating the marriage.

This provides no relief for a person whose spouse becomes mentally ill with no prospect of recovery. Cases are not uncommon where the person in this difficulty resorts to an extra-marital relationship or an American divorce, which is not valid in Canada.

Our immigration laws offer another field for scrutiny. The psychiatric grounds for exclusion from Canada or deportation are defined in an archaic terminology. For example, the Immigration Act states that no person shall be admitted to Canada if he is an "idiot, imbecile or moron," or if he is "insane." These terms are not used in most of the provincial statutes or in medical circles. Perpetuation of their use in a federal statute may lead to uncertainty in their interpretation and application to a particular case.

Another topic which presents difficulty at times is sexual sterilization. It is generally accepted that it is lawful to sterilize a person, with his consent, to preserve his physical or mental health. There is uncertainty about sterilization, with consent, to preserve the health of the spouse or to prevent transmission of hereditary defects to offspring or for economic reasons. The old woman who lived in a shoe would probably get no help from even the most sympathetic Canadian doctor. She would be told that sterilization, even with her consent, was illegal.

Legislation governing the admission of patients to mental hospitals requires revision from time to time. Some patients are admitted involuntarily. The element of compulsion and deprivation of liberty necessitates statutory provisions which are not required in the case of other hospitals.

(concluded on page 94)

The author is associate professor of psychiatry at the University of Toronto.

Kindergarten Music Therapy

Research Institute for Children

at London, Ont.

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"PROGRESS is not an accident—but a necesssity." Spenser's words epitomize the new approach to the problem of mental retardation. The concept, planning and development of this institute by the Mental Health Division of the Ontario Department of Health demonstrates the government's intention to meet the need and to keep abreast of new developments in this field.

The choice of the site in London is an ideal one for several reasons: (a) the interest shown by the medical school of the University of Western Ontario in research; (b) the availability of adequate facilities for present purposes at the Beck Memorial Sanatorium, and (c) the long wished for close university affiliation where clinician and researcher may work together on the many problems of mental retardation.

The clinical program will be directed toward the evaluation and management of mentally retarded children referred by physicians and agencies in western Ontario. A fairly recently constructed fireproofed building will provide space for both out-patient and in-patient departments. The children will be seen first in the out-patient department where the aim will be:

1. To arrive at an etiological and pathological diagnosis of the child's condition.

2. To evaluate the present level of intellectual and emotional function and to estimate the child's potential for further development.

3. To assess the patient, his family and his *milieu*, using the team approach of psychiatry, paediatrics, psychology, social work, nursing, teaching as well as other medical specialties as they are required.

4. To help the parent decide the best course of action for the immediate and future management of the patient.

5. To be a guidance centre for continuing care of the child.

It is becoming more and more the accepted feeling that many retarded children can and should be kept at home and that hospitalization is far from indicated just because a diagnosis of mental retardation has been made. There is ample evidence to show that intelligent home care by loving but not overprotecting parents is needed to ensure the achievement of the child's optimum potential as is the case with any child. Today there are numerous community-sponsored facilities to assist in the home care and education of the retardate. It is the intention of those of us at the institute to work as closely with these facilities as possible.

The in-patient service will for the first year consist of about 50 beds. To ensure optimal use, these facilities have been designed to make each bedroom as flexible as possible so as to meet the demands of the various age groups in both the sexes. Admissions will be advised:

1. When a period of close continual observation is required for diagnosis and assessment.

2. When some aspect of training is required which could best be initiated intramurally and later continued in the home.

3. When there is a need to relieve the family at times of additional stress in the home, short term care may be arranged.

4. When it is advised, mothers of children attending the institute will be admitted along with their children. This will enable them to take part in the training program and be better equipped to care for the child at home. This period can be utilized to teach the staff the problems of home care as well as provide group and individual guidance and psychotherapy for the mother.

5. When children are undergoing special investigation by the research group. These patients may come from the group of patients attending the out-patients service as well as from those resident in Ontario Hospital Schools in the province.

The presence of the university so close at hand will provide a constant stimulus for all aspects of the work at the institute. There has for some years been a group at the University of Western Ontario Medical School involved in basic research in mental retardation. The work done by Dr. Murray Barr, for example, has already won international recognition. There will be 20 beds set aside for patients under investigation by this group. All professional staff will be encouraged to assist the group in this work as well as to become involved in teaching and research related to their own particular disciplines.

The program outlined will be implemented in stages beginning this month with the out-patient department. Then as redecorating and refurnishing of the building is completed and additional staff recruited, the research beds will be put into use in April of this year. This will allow a minimum time interval for ward staff training

(concluded on page 94)

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The Volunteer

in Psychiatric Service

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Toronto, Ont.

VOLUNTEERS have been used in the mental health services for many years in various ways and with varying degrees of success. We have not developed systematic policies and procedures for the fullest possible use of volunteers, nor have we done much in the way of retrospective evaluation of volunteer services. Who are the volunteers? What can they do and what can we ask them to do? When is it appropriate to use a volunteer instead of a regular staff person? How much responsibility can we delegate to a volunteer and how much careful control must be exerted over his activities? Why are volunteers willing to give their time and by what means can we respond to this motivation and use the energies that lie behind it?

We begin with the assumption that there is an important array of jobs to be done in the mental health services by volunteers. It is further assumed that these services have considerable value for (a) patients; (b) the hospital, clinic or other mental health facility; (c) fellow citizens, some of whom are potential patients and patients' relatives; others—potential employers, neighbours, et cetera; (d) the volunteers themselves, who stand to derive emotional benefit from the satisfactions gained in giving and ministering to others.

Who are the Volunteers?

They are the persons who *give* their services, some occasionally, others regularly but on a part-time basis. These services may be administered direct to patients or to the members of the staff of a mental health facility to assist them in implementing or enriching the therapeutic program available to patients or ex-patients. The volunteer is more than a donor; the volunteer gives personal service involving his time, rather than material gifts. The volunteer service is planned as an integral part of the therapeutic *milieu* or treatment plan and it is designed to contribute to specific objectives. The volunteer is therefore an adjunct to professional staff and not isolated from them, whether he works individually or as a member of a group of volunteers. Volunteers should be from all segments of the community.

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The matter of appropriate assignment is singularly important. If we begin with the premise that there is a job to be done that calls for volunteers, we are really enunciating the principle that volunteers are perhaps peculiarly well qualified to perform a service (a) because they are volunteers and not regular staff; (b) because they represent the ethos of the community external to the mental health facility; and (c) because it is permissible for the philanthropy and the zeal of the volunteer to show in our society where professional staff are expected to be disciplined and objective.

The interests and abilities of the volunteers may reflect the whole spectrum of vocations and avocations, aptitudes and skills of the adult population of the community. Hence, there are many possibilities for assignment.

The assignment must coincide with the priorities of the mental health program; *i.e.*, volunteers are sought to implement programs in response to real needs. While volunteers should never replace or displace regular staff, their assignments involve real work, considerable talent and in-service training to ensure best performance. The assignment should lead to a positive experience for the volunteer to bring about the best service for patients, ex-patients and fellow citizens. But we must always maintain primary focus on the recipient of services and the extent to which the program meets his needs. The benefits of the volunteer receive only secondary concern.

Orientation of Volunteers

The volunteer must have a clear conception of what is expected of him. His eagerness to serve is vitally important but it is not enough. He needs help in applying himself to a task that is new to him in a setting that is unfamiliar. Orientation to the mental health facility is essential—orientation to its function, its policies and its over-all program—whether it is a hospital, clinic, ex-patients' club, a mental health education centre or an organization of friendly visitors in the community.

The volunteer needs help in doing the job assigned to him. He needs help in adapting himself, his skills and his impulses-to-help to the special needs of the mentally ill, the convalescent, and the discharged patient who needs a friend and a helping hand. He needs some orientation to the field of mental health and not a course in elementary psychiatry; just as he needs a sharpening of his awareness of mental illness and not a course in psychopathology. He needs an indoctrination program which helps him to see how his assignment fits into the pattern that contributes to the welfare and recovery of the patient or how the service he renders supports a program which ultimately benefits patients or the community.

There are various patterns of training: some hospitals (*e.g.* in the United States) employ full time co-ordinators of volunteers who provide in-service training; some hospitals delegate responsibility for volunteers, their training and supervision, to a department of the hospital (*e.g.*, social service, occupational therapy recreation or nursing); some mental health facilities depend on the local branch of the Mental Health Association for these services.

If we think of selection, train-

ing, assignment and subsequent supervision as interlocking links in a process, we might find some kind of assignment for most would-be volunteers. If a mental health facility already has a volunteer program under way, the corps of volunteers are valuable recruiters and will tend to introduce good candidates for volunteer work. However, responsibility for selection should not rest with the volunteer who may find it awkward to be held responsible for more than introducing a friend who displays interest.

The suitability of volunteers for direct service to patients can be assessed at different stages. Initial impressions may be confirmed or modified during the orientation period. If assignments create more anxiety than the volunteer can bear, re-assignment to a more indirect service can be made. If the assignment for another person is too routine and fails to stimulate him, then re-assignment is also advisable. Disappointment and misgivings are expressed to the supervisor and require careful attention.

Continuity of program is an administrative problem for supervisory staff. Volunteers provide important fragments, priceless bits that must be pieced together. Implementation of program is an administrative problem involving assignment, supervision and evaluation. Helping the mentally ill or convalescents within the context of a treatment situation is not left to volunteers who are amateurs. We must define the job, explain the relevance of the job, assist the volunteer in performing his duties on the job, interpret how this task fits in with other services, help the volunteer to improve his skills, deal with the doubts and misgivings expressed by the volunteer, maintain interest by handling his questions about mental health and mental illness in relation to his assignment and provide for periodic assessment of progress. This provides a safeguard against volunteers' plunging headlong into matters that are clearly the province of professional staff. At the same time it is intended to provide for recognition of the valuable service rendered by the volunteer and protection against creeping exploitation beyond the scope of jobs described as volunteer assignments. Group supervision supplemented by individual sessions has proven to be sound and economical.

The volunteer must know to whom he is accountable and with whom questions should be cleared. An understanding of chain of command is valuable in any organization but we obviate difficulties for the volunteer if he knows whom to consult and when not to proceed without consulting that person.

Orientation and indoctrination of the volunteer are essential. The professional person receives an education in preparation for practice; the technician receives training; and the volunteer receives an indoctrination. In each instance, learning and teaching occur.

If the volunteer receives an indoctrination which embraces more than "how to do it" he will learn something about mental health and mental illness, the program available in the mental health facility to which he is assigned, gaps in programs or unmet needs of patients, the experience of patients and the anxieties they have about their illness, treatment, hospitalization and return home. He learns these things and many more. The importance of his indoctrination is not limited to the job expected of him while he is a volunteer in the hospital or other mental health facility. It extends to the sphere of influence that the volunteer has within his own social circle and encompasses the attitudes and information that the volunteer transmits to persons with whom he has contact; people who might be variously classified as friends, neighbours, co-workers, customers, tradesmen, employers, creditors – all people playing different rôles in community life.

The indoctrination is, of course, intended to help the volunteer adapt his personal experience and aptitudes to the requirements of his assignment. This is not calculated to cancel out the fresh, warm, spontaneous quality of the volunteer; nor is it intended to dampen his enthusiasm and his zeal. It must not tarnish him with professionalism. It should give him security in performing assigned duties by defining limits within which it is safe and sound for him to work.

Rôle and Services

Why do people volunteer? Volunteering may be rooted in concepts associated with religious ethics and civic responsibility or collective security in a democratic society. Some volunteers fill otherwise empty hours; others squeeze volunteer work into staggering schedules. Regardless of the extent to which one sacrifices one's free time, it is probably the philanthropic impulse, the wish to serve one's fellow man—with all the understandable and legitimate secondary gains that go along with this motivation—that attracts the volunteer.

The volunteer bridges the gap between the hospital and the community. He is a public relations agent for the professional staff. Every time he explodes a commonly held misconception and whenever he describes hospital activity to persons in his own social circle he is, consciously or not, carrying a message of importance to the public.

Volunteers who devote their time to activities in the hospital for the mentally ill afford social contact and personal attention through friendly visiting with patients, dances, parties, quiet games and athletic events (determined by the individual patient's readiness), taking patients on shopping trips, swimming and bowling parties, et cetera. Others operate the bookmobile; still others assist professional staff in the occupational therapy shop. The volunteer manicurist or beautician is a real morale builder.

(concluded on page 88)

C.M.H.A. members and patients turning out "News and Views"

Professional Activity Study

its application to Saskatchewan

M. S. Acker,
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WE ARE all keenly conscious that these are days of rapid change, both in the organization of health services and in medical science and technology. As new programs evolve and new techniques for patient care emerge, there is an increasing need to have a closer look at the quality of our services. And to accomplish this in a meaningful and constructive way, we must discover practical methods to measure quality and to objectify our approach.

In other words we must know where we are going toward our health objectives, and if changes are made, we must be able to demonstrate, if possible in measured terms, that the change was a progressive one.

In Saskatchewan we are near the completion of 13 years of experience with universal and comprehensive hospital insurance. During this period, this hospital plan —based upon a firm partnership of government and voluntary hospitals—has had a profound effect upon the hospital system. Apart from inflation which is essentially outside provincial economic control, the plan has in general stabilized hospital financing. Hospital construction and modernization has proceeded apace with the added support of federal grants and provincial capital grants.

And this system of modernized hospital facilities under the financial umbrella of hospital insurance has certainly provided—if nothing else—a higher volume of care than ever before in its history. Utilization has climbed to new heights and has continued at a plateau of about 2,100 days per 1,000 of the population per year; and I think we can expect the same trend to occur in the other eight insured provinces, although not necessarily reaching the same plateau.

But I do not believe this sharp rise in the quantity of hospital care is a retrograde development as such. There are undoubtedly a host of positive values in the fact that many more persons have obtained the benefits of modern hospital care, free of any financial distress, than was ever the case before.

At the same time, hospital boards, hospital administrators, medical staffs and the community at large must critically examine the amount of hospital utilization. Is it excessive? Is a high proportion unnecessary and wasteful as the mass-circulation magazines like the *Reader's Digest* and *Look* claim? Can sheer volume of hospital care have a harmful effect on quality? Are we fully justified in the way we are spending the health dollar in the light of our health objective?

These are questions we must ask ourselves frankly and seek answers which are factual and objective. In this way we will best serve the public interest and the interest of the health professions which fundamentally coincide.

Let us examine the PAS system of looking at quality and ascertain whether it can help us look at the facts.

The Professional Activity Study is a system of abstracting relevant clinical and social data from hospital records, grouping these data in a meaningful way by mechanical means—and presenting these data in a comparative scheme so that valid differences can be observed and valid conclusions drawn.*

This methodology is of course not entirely new. It is in essence the method of epidemiology applied to hospital care; and applied, I believe, with considerable skill and ingenuity.

Epidemiology as an investigative method goes back a long way in our medical and public health history. Indeed we can look back at least 100 years to that genius Dr. John Snow, who in his writings, *On the Mode of Communication of Cholera*, described how he identified the mode of transmission of cholera in London in the 1850's and logically arrived at the necessary control measure. And Dr. Snow accomplished this in the pre-bacteriology era before anyone knew that the vibrio cholera existed.

Existing Methods for Evaluation of Patient Care

Before we examine the applicability of the PAS approach within the setting of Saskatchewan, perhaps we should ask ourselves these questions:

1. Are there other methods, already in use in this province which enable us to measure and promote a high quality of patient care?

2. Are these methods adequate? Are they achieving their purpose?

The author is director, co-ordination and planning branch, Saskatchewan Department of Public Health. From a paper presented at the 41st annual convention of the Saskatchewan Hospital Association, held in Saskatoon, October 16, 1959.

**The method of the Professional Activity Study is fully explained in "PAS", a brochure prepared by the Commission on Professional and Hospital Activities Inc., First National Building, Ann Arbor, Michigan.*

Medical Manpower in Relation to Hospital Facilities

TABLE 1

Distribution of medical practitioners in district and community hospitals by hospital size and number of practitioners in the community, Saskatchewan, September, 1959

Number of medical practitioners* in each community	Number of hospitals with specified rated capacities				
	Total	Under 25 beds	25-49 beds	50-99 beds	100 beds
Total	129	103	18	8	—
0	4	4	—	—	—
1	72	69	3	—	—
2	29	24	5	—	—
3	13	6	5	2	—
4	4	—	3	1	—
5	3	—	2	1	—
6	2	—	—	2	—
7	—	—	—	—	—
8	2	—	—	2	—

TABLE 2

Distribution of medical practitioners in regional hospitals, Saskatchewan, September, 1959

Regional hospital	Rated bed capacity	Number of medical practitioners* in community
Assiniboia	38	5
Humboldt	75	5
Moose Jaw A	244	51
B	155	
North Battleford	175	20
Prince Albert A	112	35
B	144	
Rosetown	38	3
Swift Current	114	17
Tisdale	75	3
Weyburn	78	10
Yorkton	143	20

TABLE 3

Distribution of medical practitioners in base hospitals, Saskatchewan, September, 1959

Base hospital	Rated bed capacity	Number of medical practitioners* in community
Regina A	757	178
B	464	
Saskatoon A	323	212
B	253	
C	532	

*Data excludes physicians in tuberculosis sanatoria, mental hospitals, full-time public health, medical administration and research.

TABLE 4

Distribution of medical record librarians in Saskatchewan, September, 1959

	Number of hospitals in this category	Number with medical record librarians	Number medical librarians on staff
Total	146	17	20
Base hospitals	5	4	5
Regional hospitals	12	5	7
Other hospitals	129	3	3
Special locations	—	5	5

Note: These figures refer only to **registered** medical record librarians. Special locations include a large medical practice clinic, a cancer clinic, a tuberculosis sanatorium, a regional hospital council and the provincial health department.

3. If there are gaps, should they be supplemented by more advanced techniques such as PAS?

It has been aptly stated that hospital care is multidimensional. It is a service provided by a co-ordinated group of professional, technical and other workers under the direction and leadership of the physician. The quality of care which patients receive is affected by the adequacy of facilities and by their maintenance; by the administrative and professional organization of the hospital; by the competence and the motivation of the staff; and by the interpersonal relations among staff as well as between staff and patients.

This surely is a medical-social complex with a length, a breadth and a circumference. Therefore any complete evaluation of patient care must take account of the numerous influences which are involved.

While there is ample justification for focusing our enquiry on the clinical element of patient care—which after all is the heart of the service—we must not forget the profound effect of supporting paramedical services and of administration.

In this province we can observe a number of ways in which hospital care is subject to evaluation — methods by which a great many, if not all, of the influences are taken into account.

First, we can look at our hospital statutes and regulations governing the standards of hospital facilities and operation. These are a set of minimal and frequently optimal standards which the health department has evolved after extensive consultation with hospitals and medical and other professional groups. They represent achievable standards and they are backed by a system of public financing which encourages their achievement.

In practice, the level of facilities and the adequacy of operations of hospitals can be matched against these accepted standards. They not only serve to regulate or to distinguish the "good" from the "not good enough" but, more important, they stimulate improvements on a province-wide basis.

Second, also on a province-wide basis, a large body of quantitative data has been derived from the operations of the hospital insurance program. Working with the extensive utilization data and the specific morbidity data which the hos-

*For references, see page 56.

pital plan provides (also made possible as with PAS through the use of data processing machines), we have been able to examine and measure many facets of our experience.

The annual reports of the Saskatchewan Hospital Services Plan contain a rich mine of information on differential rates of illness, on hospital case fatality, on the relative rates of operative procedures and other characteristics of hospital care.

Perhaps the most productive data have come from special studies. These have included investigations of dental admissions, measures of the interval between admission and operation for surgical cases, longstay studies on a province-wide basis and for individual hospitals. Individual hospitals, moreover, periodically receive tabulations on their discharges classified by length of stay and by diagnostic category. It is possible for the hospital to match its experience against similar hospitals in the same size group.

A special study of major surgical procedures linked with data on type of anaesthesia and the presence of surgical and anaesthetic assistance was carried out at the request of the Health Services Planning Commission. In this instance it was possible to compare practices with the standards laid down by provincial legislation. There have been other studies of accident data, alcoholism, and the survivorship of immature infants in various regions and hospitals of varying size. Of the published reports, perhaps the most extensive was a study which measured the impact of a range of medico-social factors on hospital utilization[3]. Taken together, these studies have been of considerable value in planning the forward development of our hospital system and improving hospital operations.

I should like to mention one point in statistical methodology which is of considerable importance in regard to analyses of S.H.S.P. data and is also relevant to an examination of the PAS method. Data derived from a system of contributory hospital insurance with universal coverage encompass the entire population. Because of this fact, utilization and morbidity data can be directly related to measurements of the population from which the patients came. Moreover, characteristics of the patient population can be directly related to social and demographic characteristics of the total population. This applies to the province as a whole and to defined geographic regions. This means that indices for different areas with known populations can be compared, thus largely eliminating the problem which statisticians call selection.

We are aware, of course, that the analyses which PAS produces are meaningful in many ways, notwithstanding the fact that the data are "hospital-centred" as it were, and cannot be related to the parent population from which the patients came.

Let us return to a third way in which patient care is now evaluated and improved as a result of such evaluation. I refer to the inner organization of hospitals themselves. Hospitals in this province, as elsewhere, establish medical staff organization based upon an accepted set of medical staff by-laws.

Here is a workable system by which medical staffs can pool their knowledge, judgment and experience in the evaluation of hospital and patient care. Special subcommittees, such as medical records committees, tissue committees, x-ray and laboratory committees and others, can examine particular facets of clinical activity. The larger hospitals in the province, of course, are in a preferred position in achieving benefits from this system. However, it is theoretically possible for a hospital with two physicians to have them form a staff organization and share their thoughts and their constructive ideas.

At this point I should mention the rather special group procedures which are used in the specific disease programs such as in the cancer service, the mental hospitals and the tuberculosis sanatoria. In these settings, with full-time staffs having, perhaps, a greater degree of mutual professional interest, evaluative discussions on patient care are conducted at daily or weekly group conferences. At these group sessions, one can observe a back-and-forth, critical, face-to-face evaluation of diagnostic, therapeutic and after-care measures.

There are other approaches which I shall only mention: the maternal mortality committee which is a joint undertaking of the College of Physicians and the health department; and the College committee which studies deaths associated with anaesthesia and surgery.

In this review of existing measures for evaluation of patient care, I do not propose to lose sight of the individual physician and the clinical skills with which he applies scientific medicine to the care of his patient. And while we may look to epidemiological and statistical methods for answers to many problems, the physician attending his ill patient must look to his personal knowledge and accumulated experience to prevent disease and restore the patient to health as well as to assess the efficacy of his prescription. One would expect, however, that the family physician would seek out information beyond his personal capacity to acquire which could help his own evaluation and render his efforts even more productive.

Applicability of the PAS Method to Saskatchewan

If we think back to the various methods of evaluation which are now used in our hospitals, I think we can discern a need for an extended and perhaps more precise approach. What we are doing now, effective as it might be, could gain considerably from the more systematized and continuous production of data which the PAS method allows. While this would mean the abstracting and mechanical recording of more data than we are currently taking from our records, I suggest that the results of the additional effort would be very much worthwhile. Certainly from the comparative studies which the PAS system produces, our medical staffs could at the very least ask themselves many more questions than they are able to at the present time.

Can it be done in Saskatchewan with its large number of small hospitals and with the dispersion of our medical manpower? I think that the proper application of this method requires for each participating hospital at least the presence of a trained medical record librarian. Moreover, it would require a moderate level of adequacy in the documentation of medical records. Most essential, of course, would be a definite interest on the part of physicians and effective medical staff organization.

If you will examine *tables 1, 2 and 3* you will find data on the current distribution of our medical manpower in relation to the hospital system. Below the regional level there are 129 district and community hospitals and no less than 103 have capacities of fewer than 25 beds. Of all the communi-

ties where these hospitals are located, 105 or 81 per cent have two or fewer resident physicians. As you will note from *table 4*, only three of them have registered medical record librarians.

However, there are a substantial number of physicians located in all of the communities where there are regional or base hospitals. Moreover, we note from *table 4* that, at present, there are registered librarians in four of five base hospitals and five of the 12 regional hospitals. An additional eight librarians are awaiting their qualifying examinations and three are away for training with provincial bursary assistance. From these data one can conclude that there are possibly about a dozen hospitals which potentially could agree to participate in a PAS type of evaluation.

How might we approach a project of this kind, assuming there was a demonstrated interest on the part of medical staffs and hospital boards? I do not, at the moment, feel it could be done through an extension of the S.H.S.P. admission-discharge form which requires uniformity across the province. It is quite possible, however, for a group of the major hospitals to join in an experimental effort and test the mechanism, perhaps on a trial basis at the beginning. It is entirely conceivable that the Department of National Health and Welfare, together with the Canadian Hospital Association, would be interested in supporting such a project. It is my personal feeling that it need not be confined to one province but might encompass groups of hospitals in adjoining provinces, all of them sharing in the task of tabulating and processing the data. I am certain there are other avenues of approach which could be explored.

The problem, as we have seen, is more difficult for the smaller hospitals. Here again, however, groups of hospitals which have joined forces in regional hospital councils might examine the possibilities, especially those hospitals which have medical record librarian consultants. In this regard it is worth noting that the PAS is being carried out in some smaller participating hospitals in the United States by non-librarian personnel who have been specially trained. Moreover, in our setting medical health officers in the regions are ex-officio members of the medical staffs of the hospitals and, with their medical and epidemiological training, they could give considerable advice and assistance.

Ontario Coat-of-arms unveiled at Orpington Hospital in Britain

The coat-of-arms of the province of Ontario was recently unveiled at the Orpington General Hospital in Kent, England. Seen here after the unveiling are (left to right) Mr. J. S. P. Armstrong, Agent-General of the province, who performed the unveiling ceremony; Mrs. Armstrong; Mr. Frederic Hudd, former Deputy High Commissioner and a past president of the Canadian Veterans' Association; Miss A. Handcock, matron of the Orpington Hospital; and Mr. H. J. Lester, chairman of the Orpington and Sevenoaks Hospital Management Committee.

The handsomely carved wooded emblem was presented to the hospital by the Ontario government and now hangs in the main reception hall to replace the emblem destroyed by fire last June.

The Orpington General Hospital was first known as the Sixteenth Canadian General Hospital and was built by the Ontario Government in 1916 for Canadian and other Commonwealth troops wounded in the first world war. It was handed over to Britain in January, 1919. Between 1916 and 1919, 26,278 Commonwealth troops passed through the hospital.

Conclusion

In this era of national hospital insurance with rising hospital utilization, the need to take a closer look at the quality of patient care becomes more important. At present there are a range of methods of evaluating quality which are currently in use in this province. I think we can honestly say that these methods could be strengthened in themselves and supplemented by more systematic methods of measurement.

One such method is the Professional Activity Study which has certainly broken new ground in the hospital field in the United States. There appears to be a practical basis for the application of this method in Canada and in Saskatchewan, to begin in a few selected hospitals and adapted to suit our conditions.

In the end we should recognize that this method—like automation—is an efficient precision instrument. But the effectiveness of this instrument will depend upon the data which the human mind puts into it and the wisdom with which this mind analyzes the results.

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The Evaluation of Medical Care

—an internist's view

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THE real purpose of evaluation studies of professional activities in the medical or hospital fields should be as educational techniques in order to raise the standards of hospital and medical care. That other uses might be made of some of the statistics, where warranted or unwarranted conclusions might be drawn for punitive or propaganda purposes, is always a possibility. So when we embark on such studies, we need to be as sure as we can of the accuracy of the observations upon which the statistics will be based so that valid and reasonable conclusions can be drawn for educational purposes.

The need for the highest quality medical care has always been a concern of our medical schools and university hospitals and most of our professional organizations. As society moves increasingly into the provision of more hospital and health services of all kinds, concern for the quality of care should become an over-riding consideration of all medical and non-medical administrators who are planning these changes. That some of our leaders are alert to these matters can be appreciated by any who read professional and lay magazines.

Andrew Patullo[1]* in 1957 said "The public are increasingly interested in the quality of hospital care". Mr. Monteith[2], the federal minister of health, in January 1959 said in part, "We have seen to it that the hospital insurance program itself will foster the continuing of improvement in hospital care. Special machinery has been built in the provincial plans for this very purpose, but this machinery cannot do the whole job. A good deal of responsibility must still rest with the medical profession and hospitals. Experience shows that high quality care can best be insured by doctors and hospital authorities working together".

Therefore, any well thought out plan for analyzing or evaluating and/or assisting the efforts of medical men and the hospitals to improve their services should be very carefully examined. If it, or any modification of it, can be applied to one of our local hospitals or hospital regional councils or any part of the provincial health industry it might provide us with statistical tools and educational techniques that could be of great value.

It is said that the hospitals which voluntarily participate in a professional activity study (PAS) gain a greater understanding of the standards of their medical and hospital work. The reports allow them comparison with those of other institutions and as a direct result greater efforts toward refinement of medical and surgical care in these hospitals should result[4].

Dr. Vergil Slee* has made the point[5] "That overworked physicians and harrassed administrators deserve reports of this kind which will enable them to improve the quality of patient care while at the same time conserving time, funds and energies". He makes the additional points that these informative reports are forthcoming, without burdening the hospital, and making no new demands on the medical staff save for the completion of medical records in the usual way.

Medical Records

Here is often the crux of the situation, namely, the completion of medical records. These, of course, must be done to make any system of evaluation operate, whether it is statistical[6], scoring[7], or so-called scientific[8] in nature. In particular, these records are necessary for any realistic medical appraisal or medical audit which Dr. Slee has definitely distinguished as different from the professional activities study.

That the problem of completion of medical records is no news to hospital authorities is indicated by what Dr. Irial Gogan[9] said at the Canadian Hospital convention in Saskatoon in 1957: "The problems of hospitals, in relation to both the medical audit and for accreditation purposes, very frequently boil down to the question of medical records". Then he asks the $64,000 question — "How can completing medical records be made more attractive to the medical staff?" Among a few of the suggestions that he was offered in reply were:

1. Increasing the number of dictating machines and dictating points throughout the hospital. This presupposes, of course, that there are enough medical secretaries to deal with the output of these dictating machines.

2. In the final analysis, it was said that the medical records committee had to get out the "big stick".

The "big stick" technique, of course, should be combined with the "carrot" technique. The first works best in an authoritarian atmosphere. A combination of these has to be the answer to the relatively free society in which most of us work. In my own experience, I had the very great privilege of training at one of the finest hospitals in this country. I remember that in those years, working as interns and residents, we lived in a more or less authoritarian, dogmatic and generally other-directed atmosphere. You either wrote your histories and did your work successfully or satisfactorily, or you were not likely to get further appointments or recommendations for professional advancement. Records on the public ward teaching service, completed by interns and residents,

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The author is chief of medicine, Providence Hospital, Moose Jaw, Sask. From an address given to the Saskatchewan Hospital Association, annual meeting, October 1959.

For references, see page 92.

**Executive director, Commission on Professional and Hospital Activities, Ann Arbor, Michigan.*

with progress notes and consultation letters completed by the attending staff, were in the main well done. On the private ward service, in those days, this was not the case. Some of the records there were very sketchy indeed; and others were practically devoid of any material of historical value. This is not to say, however, that the quality of the work done at that time was not satisfactory. However, I would venture to say that more histories and complete records are now being written in our two small city hospitals percentagewise than was the case on the private services of great hospitals in this country 20 to 25 years ago.

In many non-university hospitals interns are a rare commodity. University hospital centres, and their allied hospitals, manage to absorb the vast majority of the available supply. So the attending physicians, working in hospitals outside this hierarchy, are responsible for all this work.

In our hospitals we recognize that we are still a long way from fulfilling all the requirements of the Hospital Standards Act of the provincial government[10] or the Canadian Council on Hospital Accreditation[11]. However, to meet all these requirements, if ideally fulfilled in all particulars, would require either double the number of medical personnel and record room workers or cause the present ones to work greatly in excess of what they are now doing.

The need for good records is also made more desirable by the never ending requests for more and more certificates of all kinds and for health records for almost every conceivable type of medical examination that obsessive and/or enthusiastic administrators can dream up.

It seems fair to say that over the past ten years a considerable improvement has occurred in our two city hospitals as a result of several factors; namely, the provision of dictating machines, more record room personnel, and a combination of the "big stick" and "carrot" treatment. Visits regularly conducted by field representatives of the accreditation organization certainly deserve some credit. Unqestionably their reports, and statements at medical staff meetings that such and such a technique is now required for accreditation, often act as the magic word, for loss of accreditation is a blow to the status and prestige of the medical staff and the hospital concerned.

Notwithstanding the above potent factors, however, a most important reason for the over-all improvement that has come about in our experience in Moose Jaw (having regard to quality of work, and in particular better records) has been the obtaining of more well qualified medical personnel and more services, together with more trained hospital record room people. The example of several senior surgeons and physicians in communities who delight in making good records has an over-all effect, especially on the younger doctors arriving on the scene. This is very important. A sound example set by those with whom one is working, especially if they are senior and respected persons, is still one of the best important factors in stimulating best efforts.

Any physician or surgeon who has been trained in a basically philosophical atmosphere, where a "cultivation of the first-rate is stressed" knows the importance and desirability of good medical records. Dr. Samuel Levine, one of the best teachers of cardiology I ever listened to, used to say: "I know I am slipping when I fail to keep up accurate recordings of my histories and medical data".

But the fact remains that the pressure of work and the failure to establish good habits of record keeping, sometimes the lack of modern devices to take the drudgery out of record keeping, to say nothing about the quality of medical penmanship, make these desirable objectives of good and complete medical records difficult to obtain.

Evaluation Techniques

Generally in accredited hospitals, the development of tissue committees and obstetrical review committees has been a forward step. Both these appear to have been helpful in terms of control of surgery and operative obstetrics. Justification for these surgical procedures is necessary and subject to the committee appraisal. However, it often happens that members of the tissue committee themselves are not in a position to evaluate the pre-and post-operative surgical care; nor the excellence of the surgical technique employed.

At the provincial level the Saskatchewan College of Physicians and Surgeons, working closely with the Department of Public Health, has developed a child and maternal health committee[12]. This group inquires exhaustively and searchingly into all maternal, neonatal and stillbirth deaths, and the forms completed for these investigations run to 30 or more questions. The College of Physicians committee[13] on the study of anaesthetic and post-operative deaths occurring within ten days of surgery has been a development of recent years. Here again excellent work is being done to try to review and find preventable factors in each and every instance occurring in the province, and the doctors concerned are notified. That cooperation has been generally forthcoming from the medical and surgical men of this province indicates concern for high quality work. The educational value of these efforts depends in the last analysis, however, on how seriously the individual doctor pays attention to these reports.

You will note that most of the plans formulated and in operation here have dealt with surgical or obstetrical operative procedures and neonatal and maternal deaths. The problem of assessing work in the departments of medicine or on general medical services has been more difficult, and, as a result, have been later in developing. Even yet the American College of Physicians committee which have studied carefully in this field in North America are not yet prepared to make their final recommendations or release their final medical appraisal form. However, they are prepared to make a number of significant observations, and among these are the following[14]:

"No easy method for evaluating the quality of medical care by objective criteria could be found. Many criteria first thought to be useful were found unreliable after analysis." Among these criteria usually held by the accreditation organizations to be of considerable value are the autopsy records, the consultation ratios and the number of scientific meetings held. This committee's studies indicated that where physicians of the hospital staff carefully and continuously appraise the quality of the medical care, high standards will be maintained. They recommended that the best way to assess the quality of medical practice is by systematic and critical examination of

representative patient records by the hospital staff itself, working through an appointed committee. The quality of care should be the object of attention, not the quality of the records. They have developed a preliminary medical care appraisal plan which has the following points: (a) the creation of a staff appraisal committee; (b) selecting records for monthly study; (c) study of records; and (d) reports.

In essence this provides that: self-evaluation is done by staff physicians who practise internal medicine; the quality of the medical care is judged, not the quality of the record-keeping; and the anonymity of the patient, the attending physician and the appraiser is preserved.

It is generally accepted that if any of these plans, statistical, scoring or scientific, for medical auditing and/or medical care appraisal are used in a primitive, punitive, or highly critical fashion, the scheme is likely to fall apart. For this reason it should be emphasized that it is important that the enthusiasm for this type of study be developed locally and be controlled locally. Nevertheless, it may be greatly assisted, as Dr. Slee points out, by consultative services and machine type analysis.

That some hospitals in this country have already embarked on schemes similar to this is illustrated in Dr. Gogan's recent article[15]. He outlines a plan and a form that looks something like the preliminary appraisal form of the American College of Physicians. Dr. Paul L'Heureux[16] described another technique used in his hospital to the Canadian Hospital convention here in 1957. He indicated that there was a tendency to pay lip service to tissue committees and monthly staff meetings as requirements simply for accreditation, rather than for the business of getting into the detailed analyses of cases. It is noted that Dr. Slee feels that the medical audit program developed by his commission is acceptable to the Joint Commission on Accreditation of Hospitals in the United States, in lieu of the evaluation functions of the tissue and record committees. Possibly this is one way in which Dr. Slee feels that the work imposed on physicians will be lessened. Frankly, I am not at all optimistic that any demands made on doctors in hospitals in this field will result in a lessening of work. The important aspect of this whole business, however, is to decide whether the extra work that is almost certain to be necessary is producing a higher quality of care and whether it may yield information on the use and abuse of certain procedures, which would be more than worth the efforts expended.

I have touched on some of the methods already in operation in Saskatchewan. That these are not necessarily all the techniques I freely admit, because my experience has been only in a smaller city in two non-university hospitals. It is interesting that these efforts have all taken place largely during the past five to ten years, in an attempt to control, evaluate and improve medical and surgical care in various hospitals in our province. That these efforts are not as intensive or as far-reaching as those described by Dr. Slee is agreed. Nevertheless, they are approaching the problem from a different point of view and I believe these activities represent a healthy beginning.

We have had a somewhat unique experience in this province. We have been grappling with quantity in our hospitals and medical work for 12 years or more, and it is only during the past year that the doctor-population ratio has reached one per 1,000 which is still considerably lower than in most of the United States, to say nothing of the other provinces in Canada. It is still true that we do not have the paramedical personnel in all health fields to do the job that our idealists and health leaders would have us accomplish.

The movement of health workers of all kinds in and out of the province may parallel that of the general population. It would be interesting if we knew these facts. I would really like to know what the comparable rate of travel is for doctors. Sometimes it seems like a parade. These factors are important in trying to establish continuity of efforts. The submission of one's professional activities to one's colleagues for assessment and criticism is a mature exercise and it is not something that can be accomplished successfully unless those who are to embark upon it in their local hospitals are prepared to put in a fair amount of time over several years.

That the medical profession in Saskatchewan is beginning to do this, even in the limited way now possible, is encouraging; and it is doubtful if similar exercises are carried out in our sister professions of law, education and statecraft.

The health industry in Saskatchewan, while yet unable to do all that we wish might be possible, does not have to apologize very much to anybody for the record that has been set to date. Dr. Clarence J. Houston[17] in reporting on general practice work to the B.M.A.-C.M.A. meeting in Edinburgh, July 1959, said that

Each year students in hospital administration at the University of Toronto visit the Workmen's Compensation Board Hospital and Rehabilitation Centre as one of their field trips. This year's class watches a demonstration of weaving by a patient in the occupational therapy department.

Saskatchewan enjoyed the lowest infant and maternal mortality rate in the world; that our cancer detection service was the best; that we had the lowest tuberculosis rate. Whether or not these statements are capable of valid statistical proof in 1959, the fact that Dr. Houston would make them indicates that we are not far off this position.

Nevertheless, with the exception of cancer, the other two figures, while interesting and we hope valid, are not necessarily good indicators of the quality of our current medical activities. They would be more likely found in the evaluation of our management of atherosclerosis, accidents, alcoholism, aging and anxiety.

To maintain or improve on our present position I think there are four main areas that should command the attention of any medical or non-medical statesmen involved in the planning for the health field in this province.

1. The attraction and retention of trained professional workers in all branches of health and provision for their continuing education. Without sufficient personnel to do the tremendous job that is being demanded by the public at the instigation of politicians and medical educators, we may be faced with a deteriorating service. One distinguished prairie hospital administrator[18], speaking to the 1957 convention in Saskatoon, had this to say: "The real concern is to preserve the quality of our health services." He said also: "We are facing a deterioration in hospital and health care for the next seven years." Now, without going into all the reasons, this opinion revolved around the matter of not having enough health workers — doctors, nurses and other paramedical professional people.

2. The very great need to plan and provide for the closest co-operation, as free from acrimony, resentment and bitterness as possible, between organized medicine and its individual practitioners, among the hospitals of this province, the university medical centre, the government and its Department of Public Health personnel, both centrally and in the periphery. This subject is one that needs widespread discussion and understanding.

3. The need to understand the basic economics involved in the provision of what Dr. Alan Gregg[19] likes to call "great medicine"; namely, medical education, medical service, preventive and rehabilitation medicine and medical research. To this should, of course, be added hospital science and hospital care as well as other branches of health. I submit that no group has ever worked out these basic economics through to a logical conclusion, at least as far as this province is concerned.

4. The control of quantity. Dr. Gregg says that surviving prosperity may be a much more difficult task than conquering adversity. In this province we have reached the point where we enjoy one of the highest per capita ratios of hospital beds in the country. Nevertheless, we are second lowest in the ratio of doctors per unit of population. In spite of this, there are areas in this province where it would seem to those handling voluntary prepayment plans and to hospitalization authorities that over-utilization and over-service of some medical activities and hospital visits represent a problem. This is not an easy subject. We have no real criteria yet to distinguish between good and necessary medical care and luxury care, some of which may be excellent in one sense but unnecessary in another. We have a great need to distinguish between patient and doctor needs and patient and doctor wants. We have yet no criteria to distinguish over-service as the result of obsessive conscientiousness and that arising out of motives for material gain. We have some shrewd suspicions, but as Dr. Slee points out, impressions are faulty and cannot be a very scientific way of going about rendering judgment.

In this connection, however, I think we could say that in many cases public pressures for service are sometimes excessive. These result in a situation where, as Dr. R. F. Farquharson[20] expressed it in another connection "a serious effect results in physicians being too busy to have time to think, too weary and too preoccupied to read or wonder. Being always in a rush and a hurry tends to quench the sparks of imagination and inspiration. It inhibits the power of association and dulls the memory. The care of patients then becomes more and more a matter of routine, leaving little opportunity for learning. Actually, it is easy under the best of circumstances to slip into the mechanical procedures, and it is a standing temptation for mankind to put routine, which calls for no thought, little effort, in place of judgment which calls for both." This is one of the reasons why "great medicine" has to be unhurried medicine and why I think that "hurry" should be added to the list of the seven deadly sins.

We have reached a curious paradox in our desire for comprehensive medicine. The twin pressures of positive health preaching (the practical application of which demands the understanding not only of morbid anatomy but of the psychological, chemical, social and spiritual pathology inherent in our patients) together with the desire, understandable though it may be, to have all this paid for as painlessly as possible, pushes the medical and hospital professions into a situation where they are likely to reap increasing amounts of hostility from the protagonists of both these points of view when the objectives are not readily realized.

Here in Saskatchewan, where we enjoy a relatively free society, we have to depend upon the general health workers and the quality of their enthusiasm for learning. The inner directed activities of self-education and self-discipline, with voluntary exertions in co-operative medicine that go above and beyond the call of duty, distinguish excellent or good professional care from the average or mediocre. That not all members of the medical profession in the mid 20th century are desirous of working 50 to 80 hours a week is not really very surprising. It is getting less easy to justify oneself to one's family and friends when the bulk of urban North American society is interested in working 40 hours or 38 or is it 36 a week. It sometimes seems that every time any idealistic politician, medical educator or hospital administrator feels constrained to make a health speech, he emphasizes the dilemma we are in; and he states that the medical and health professions are not working hard enough; or that there surely must be time for regular periodic examinations of everybody every year; that hospital records must be done within 24 hours; that there is too much time and attention spent on basic medical economics, et cetera. Is it any

(continued on page 90)

in the infant and child

Overnutrition

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FOR many decades great emphasis has been placed on nutritional deficiency — quantitative and qualitative. In the child, the increased needs of the growing organism will quickly result in a state of deficiency if certain nutritional requirements are not met. The rapid increase in world population with dietary insufficiency in certain areas has resulted in an increased interest in the nutritional handicaps of infants and children in these areas. The clinical picture of malignant malnutrition or Kwashiorkor reported from Africa, India and Mexico is now well documented. However, in certain parts of the world, malnutrition or undernutrition is no longer a problem and perhaps in these areas our interest should be turned toward the possible hazards of overnutrition.[1*].

Overnutrition

It is now generally accepted that obesity contributes greatly to the development of coronary occlusion, atherosclerosis, hypertension, diabetes mellitus and a shortening of the normal life span in the human adult. Dietary restriction of certain fats and an increased intake of protein is advocated by many physicians.

If overnutrition and overweight is harmful to the adult is it not possible that this could also be harmful to the child?

The case of overfeeding has been known for some time. Actually some physicians classify overfeeding as a form of malnutrition. Recently Johnson[2] in the United States has reported in a survey that 10 per cent of the child population can be classed as definitely overweight. Generally the older clinicians in the past were convinced that the fat infant tolerated certain diseases poorly when compared to his thinner counterpart. Such diseases as gastro-intestinal and pulmonary infections are tolerated poorly by obese infants. Eczema patients are often improved with a reduction in body weight as are asthmatic infants. Baumgartner[3] has shown that although there is an increased mortality in newborns with low birth weights there is also a greater mortality for the large, heavy newborn infant.

Today the modern mother is being constantly bombarded with advertising suggesting that bigger babies are better babies. Paediatricians are not altogether free of blame as many encourage the feeding of solid foods almost before the umbilical cord has been tied. Indeed in a recent survey in the U.S.A. a large number of paediatricians placed their infants on most foods by six to eight weeks of age. Some commercial companies advertise the superior value of their product because of the addition of vitamins or certain amino acids et cetera, to supplement the infant's diet for the promotion of growth.

Today the infant and child is bigger and grows faster than his counterpart of 50 years ago. The old dictum that a child should double his birthweight at six months and triple it by a year frequently does not apply to today's children, as many have doubled their birthweight by three to four months. Meredith[4] has concluded that a one-year-old infant is seven per cent taller than his 19th century counterpart, although the difference in length at birth is only one per cent. Nine to fourteen-year-old boys are six to eight per cent taller and 10-15 per cent heavier than formerly. Is this due to better nutrition, lessening of disease or genetic factors, or is it merely "hybrid vigour", or possibly related to better socio-economic conditions?

Effect on Potential Longevity

One might for a moment consider the effect on potential longevity of this rather striking increase in the weight, height and rate of growth of today's child. It is quite conceivable that changes in the rate of growth would not materially affect the length of life because the processes of ageing and senescence would proceed at their predetermined rates. However, it is possible that the rate of growth as such, might determine the rate of ageing and thus the duration of life. Accelerated growth might cause excessive expenditure, premature exhaustion of energy and thus a shorter life. Generally the life span of lower animals may be prolonged by restriction of food with reduction in body size or of vital activities. However, higher species with complex organization are, during the growth period, less adaptable to drastic food restriction than lower forms of animal life. More important, however, is the fact that we do not know at what age dietary restriction should be instituted in order to accomplish an optimal effect. Is it possible that dietary restriction should begin in the age of infancy?

In considering the effect on longevity of present day infant diets and feeding habits one must not forget that today's adults reaching 65 or 75 years of age were more commonly fed in infancy a diet lacking in vitamins and "proper nutrition" rather than having an excess. Therefore we

(continued on page 64)

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**For references, see page 70.*

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Overnutrition

(continued from page 62)

relationship of present day diets to longevity cannot be assessed until 30 to 50 years hence when today's infants and children have become older adults.

In encouraging the maximum growth the parent and frequently the physician confuse maximum growth with optimal nutrition. One may ask of so-called "optimal nutrition"—optimal for what? Do we seek the best diet or optimal nutrition for maximum growth, or freedom from disease, or postponement of death, or fitness for work or war, or reproduction, or even for cultural achievement? We must remember there is no satisfactory mathematical model for the curve of human growth and that human growth data are empirical.

Phosphorous and Protein Content

Not only are today's infants probably receiving an unnecessary amount of calories in the form of excess fat and carbohydrate, but one must also consider the possible harm from over administration of certain specific substances.

Of interest is the finding that breast milk contains significantly smaller amounts of dietary essentials than cow's milk. The average breast fed infant for the most part receives less of these essentials than the United States National Research Council recommends. Tetany of the newborn occurs almost exclusively in the artificially fed baby as a result of the ingestion of the high phosphorous content in cow's milk.

Many nutritionists are suggesting the value of increased protein in the diet of the young infant. Recent work by May[6] would suggest that the increased intake of protein in the infant's diet does not necessarily increase the percent of protein in the body composition. Harmful consequences have not been observed with increased protein in infant feeds except when water is lacking for the excretion of accumulated nitrogenous waste. However, experiments in young rats by Kennedy[7] reveal that pathological lesions ordinarily seen in the kidneys of aged rats are made to appear at a much earlier age by as little as a two-fold increase in the load of protein. Is it conceivable that this could happen to the young infant on a high protein intake?

Excess Ingestion of Vitamins

One fascinating disorder that has been reported primarily from Great Britain and Switzerland is the so-called idiopathic hypercalcaemic syndrome. This is a disorder of calcium metabolism occuring in young infants resulting in multiple signs and symptoms. These include abnormal development both physically and mentally, constipation, vomiting, abnormalities of kidney function and elevated blood pressure. The blood calcium level is found to be high. In comparison to the large number of cases in Great Britain there is a marked lack of cases on this continent. A number of causes have been suggested but there exists a strong opinion that this is partly due to the excess ingestion of Vitamin D.

British cod liver oil has approximately twice as much vitamin D as our preparation, and pre-cooked cereals are fortified with vitamin D. In Britain proprietary milk products contain three and one half times the amount of vitamin D as used in this country.[8] Of interest is the fact that increases in fortification of British foods were effected just a few years prior to the first reports of this syndrome and an analysis of the foods revealed a higher content of vitamin D than stated on the label—presumably to allow for deterioration.

In Canada the number of case reports of idiopathic hypercalcaemia have been rare with only one case having been reported by Haworth[9]. It is quite likely that other cases have existed but the symptoms have not been recognized. Certainly with the commercial pressure for the addition of vitamin D to milk and food substances and the tendency for increased concentration of vitamin D in vitamin preparations one might expect an increase in the number of idiopathic hypercalcaemia cases in the not too distant future. In the particular case described by Haworth[10], comment was made with regard to the high content of calcium in the drinking water. It is attractive to consider the possibility that some of these cases might be due to increased calcium ingestion and would warrant further investigation.

Vitamin A is unquestionably toxic when given in large doses and may produce loss of hair, painful swellings of the skin, convulsions and enlargement of the liver.

More recently evidence has been presented of the toxic effect on young newborn infants of giving large doses of vitamin K, not only to infants at birth[10,11], but also to mothers just before delivery[12]. The rather interesting finding of apparent injury to the newborn infant as a result of the administration of large doses of vitamins to the mother is of particular interest. Not only has vitamin K been implicated but also vitamin B_6. Hunt et al[13] reported in 1954 a case of pyridoxine "dependency" in a newborn child who had recurrent convulsive seizures and progressive mental retardation. The mother had received rather large amounts of vitamin B_6 during her pregnancy and the authors suggested the infant might by pyridoxine dependent since the seizures were only controlled with 2 mgm. of pyridoxine daily. The tendency today to encourage the ingestion of extra vitamins during pregnancy might be considered as potentially harmful to the unborn infant.

The apparent rise in the incidence of scurvy in Canada has been discussed by Whelen et al[14]. This excellent paper comments on the fact that of the 79 cases reported, 80 per cent received no vitamin C supplement, but 20 per cent did receive vitamin C according to the family history. Although many of the cases were from economically poor homes, others were from the higher social and economic strata and were under the care of private physicians. Although there is no authenticated instance of "vitamin C resistant" scurvy one might wonder if some of the 20 per cent described could be "vitamin C dependent". Could it be possible that some of the infants developed scurvy because of a greater requirement for vitamin C as a result of a high vitamin C intake by the mother during pregnancy? It would be interesting, although difficult, to attempt to assess the vitamin C intake of the mothers of this latter group, not for insufficient intake but for evidence of excessive ingestion of vitamin C.

The apparent increase in height and weight of today's children when compared with the normal 19th century specimens requires consideration — whether yesterdays children were undernour-

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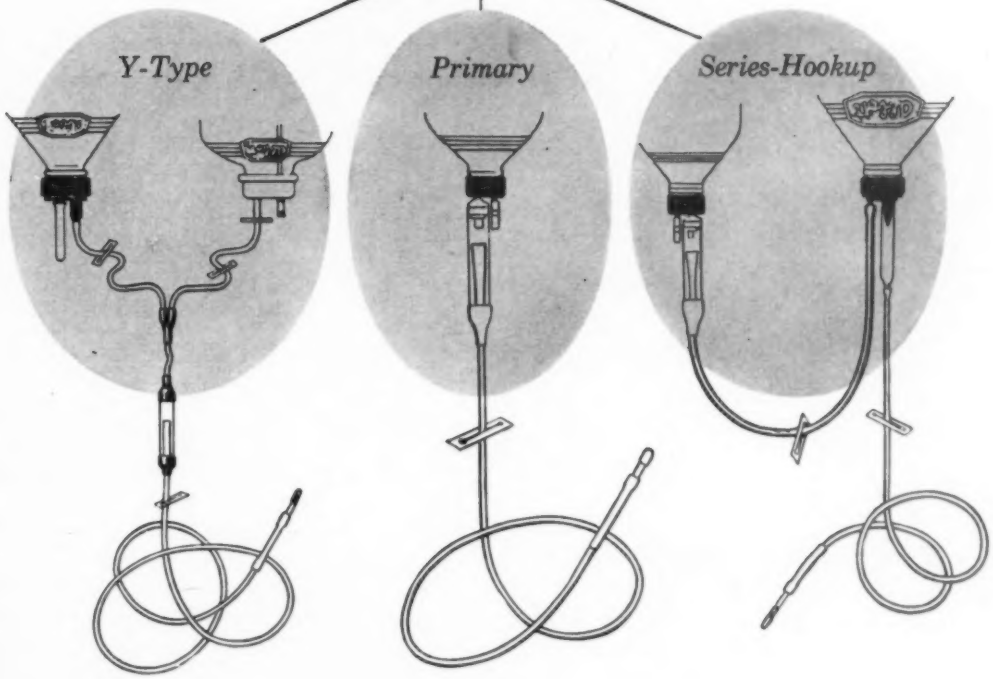

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ished, or today's children are overfed and overweight. Considering the possibility that infants and children of today are overfed and overnourished, we might ask if this can be harmful. McCay [15 16] has demonstrated in rats that overfeeding with resultant overweight and overdevelopment results in an earlier death. As yet however, in the human there is no large body of evidence to suggest that childhood obesity is harmful. Today the control of infections and the increased knowledge of nutritional requirements has resulted in a marked improvement in the health and growth of children. However, the present era is also conducive to overnutrition because of widespread promotional advertising and general availability of potent dietary supplements.

Therefore optimum nutrition for the growing infant and child will remain a challenge. The physician, dietitian and nutritionist must be aware of the possible harm from the excess ingestion of all food substances by the young growing organism. It is not impossible that future paediatric care may be concerned as much with nutritional excess as with nutritional deficiency.

Special Diets

Finally, I would like to express some personal remarks to the dietitians and nutritionists. I have not infrequently heard a dietitian express alarm regarding the number of special diets that must be prepared in many hospitals. I have no hesitation in stating that the dietitian and nutritionist must expect, over the next few years, a marked increase in the number of special diets. I say this because of the increasing awareness of investigators that certain substances in our diet can be harmful to the normal physical and mental growth of children.

As the physician's knowledge widens regarding human metabolism and biochemistry, so must the dietitian's. Unquestionably the dietitian will require a greater knowledge of chemistry and biochemistry to understand and prepare certain special diets. One might mention a few disorders requiring special diet preparations, excluding diabetes mellitus and obesity. These include: galactosaemia treated by a galactose free diet; coeliac disease treated by a gluten free diet; phenylpyruvic oligophrenia requiring a low phenylalanine diet. Certain cases of infantile hypoglycaemia may be treated by a low leucine diet; low copper diet is required in Wilson's disease, and a low protein diet in certain cases of unexplained infantile convulsions and liver disease.

Unquestionably the exclusion of certain substances in the diet will become more and more important in the treatment of certain types of mental disease.

Therefore, I would say to the nutritionist expressing concern about the number of special diets that exist today, "You have just begun to fight". You will have an ever increasing rôle in the management and treatment of many disorders in children that result in derangements of physical and mental growth.

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Valentine Canvass

In Toronto, Kingston and Gananoque (Ont.), Valentine's Day called for a house-to-house canvass for the Canadian Heart Fund which was then in the midst of its annual February campaign. The target this year was $1,246,000 from across the country and 75 per cent of this is to go for research into the cause, diagnosis, and treatment of diseases that kill 66,000 Canadians annually. — *The Globe and Mail.*

Nursing Course at Regina General

The program of student nursing education at the Regina General Hospital, Regina, Sask., will offer a two-year training course plus an additional year for internship. For the first two years, students will receive basic theory and supervised practice in the hospital.

Each student will first attend the centralized teaching program given at Regina College for a period of four months. This covers the sciences basic to a nursing course. The remainder of the two years will be spent acquiring the knowledge and skills necessary for bedside nursing. Theory, which accompanies each clinical experience, will be given on the wards under the guidance of the clinical instructor. Nursing care lectures will take the form of nursing clinics, nursing rounds, conferences and symposiums, both in the classroom and on the wards.

During their third or intern year, students will be applying the theory and practice and will be responsible to the nursing service of the hospital. Their allowances will be increased to $120 per month, plus full maintenance.

This new program becomes effective in September of this year when the 1960 student class will be admitted. — *Saskatchewan Hospital News Bulletin.*

Grant to McMaster University

A special grant of $150,000 to aid the medical research program at McMaster University, Hamilton, Ont., has been announced by Dominion Foundries and Steel Limited. The grant will be made available in annual installments of $15,000 over the next ten years. It was inspired by the rapid progress in nuclear research at McMaster.

The medical research department is engaged in the development of new tests relating to heart function. The method under study involves the inhalation of radioactive isotopes in the form of a gas; measurement of a heart condition can be made as the isotope passes through the lungs and heart. The McMaster nuclear reactor now makes possible the use of short-lived isotopes in the research program and new progress in diagnostic medicine is expected.

table 9 modal class sizes for the administrator group are shown to be 100-199 beds and 300-499 beds, and for the other two executive groups — 500 beds and over.

Another measure of the extent to which graduates have entered into the administration of the nation's hospitals is computations derived from *table 10*. Data in this table indicate that of a total of 880 public general hospitals in Canada containing 86,000 beds, 373 are 50 beds and over in size and contain a total of nearly 75,000 beds. Thirty-seven of the 373 hospitals, or ten per cent, are shown to be employing graduates. A comparison of the bed data and employment data in the table shows that 11,800 of the 75,000 beds in hospitals 50 beds and over, or approximately 16 per cent, are under the administrative control of graduates. It is appropriate to indicate, however, that to the 37 graduates serving in public general hospitals in the country must be added three employed in veterans' hospitals containing a total of 3,300 beds, four in sanatoria containing 913 beds, one in a cancer detection and treatment hospital having 7 beds and one in a home for the aged having 250 beds.

Twenty-two graduates (20 per cent of the total) are employed in non-hospital administrative positions in the health field. Of this number, nine are currently serving in health departments in the governments of five Canadian provinces in the government of Canada and in one of the United States. In addition to containing this information, table 11 reveals that government health departments have employed at one time or another 25 graduates. Provincial government health services appointments held by graduates have been chiefly in the category of hospital administration consultants within the framework of hospital care insurance programs, with the appointees advising on the operational problems of smaller hospitals.

The employment of graduates in the two other non-hospital categories, allied agencies and teaching and research, is described and amplified in *table 11*. As shown in the table ten graduates have held university appointments at one time or another throughout the past decade, and six graduates are currently so employed. Three graduates have been employed in voluntary medical care plans (all U.S.) and two currently hold appointments in such plans. One graduate is a member of a hospital consulting firm.

Table 10

Distribution of First and Present Appointments in Government Health Services, According to Jurisdiction, 1949-59, Inclusive

Jurisdiction	Number of first appointments	Number of present appointments	Total number of appointments since 1949
British Columbia	1	1	3
Newfoundland	1		1
Nova Scotia	1	2	2
Ontario	1		1
Saskatchewan	10	4	13
Government of Canada		1	1
United States	2	1	4
Totals	16	9	25

Table 11

Distribution of First and Present Appointments in Allied Services, According to Type of Service, 1949-59, Inclusive

Type of service	Number of first appointments	Number of present appointments	Total number of appointments since 1949
Hospital consulting (non-governmental)		1	1
Hospital associations:			
Local		2	5
Provincial		2	2
National	2	1	5
Medical care plan	2	2	3
University teaching and research	3	6	10
Totals	7	14	26

A Look to the Future

By means of statistical information presented in the preceding sections an attempt has been made

(concluded on page 82)

Table 12

Distribution of Canadian Public General Hospitals (50 Beds and Over),* and Graduates Currently Employed Therein, According To Hospital size, 1959

Hospital size classes	Number of public general hospitals	Number of beds in public general hospitals	Number of public general hospitals employing graduates	Number of graduates employed in public general hospitals	Number of beds in public general hospitals employing graduates
500 and above	31	23737	6	8	4483
300 - 499	35	13548	11	11	4265
200 - 299	36	8658	4	6	1008
100 - 199	140	19778	11	11	1693
50 - 99	131	9170	5	5	358
Totals	373**	74891***	37	41	11807

*Data taken from **The Canadian Hospital Directory, 1959**
**Total public general hospitals in Canada: 883
***Total public general beds in Canada: 86275

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Pamphlets Available

The National Council of Hospital Auxiliaries of Canada have a number of pamphlets which are sent free of charge to auxiliaries on request to the executive director. These contain useful information on such subjects as *Favours for Patients' Trays and Gift Shops*, and *How to plan a Convention* as well as others listed in the September 1959 *News Bulletin*. The Quebec Association has contributed (in English and French) pamphlets concerned with *Organizing a Hospital Ball, Tribute Fund, Nearly-New Shops* and *Coffee-gift Shops*.

Auxiliary to Home in Ontario

One of the activities carried out by the Women's auxiliary to Greenacres, home for the aged at Newmarket, is a program of birthday parties for the residents as well as seasonal treats and visiting. More than 200 plants were donated at Christmas. Of the 580 residents ranging in age from 70 to 96, two-thirds are women.

Verdun Auxiliary

Co-ordination of volunteer activities at the Verdun Protestant Hospital, Quebec, was effected last May in the formation of an auxiliary group of men and women devoted to raising funds for the hospital and promoting educational programs. One activity involves a woman volunteer taking a young patient home as her week-end guest where she learns to take an interest in her surroundings, learns how to cook and look after a house and even how to sew and go out shopping. Another retired volunteer now works full time at the hospital in the handicraft shop of the occupational therapy department as an instructor.

Woodstock Anniversary

This year is the 65th anniversary of the women's auxiliary to Woodstock General Hospital, Woodstock, Ontario, and plans are being made to celebrate this occasion. For some years now the auxiliary has maintained the nurses' residence and taken care of graduate social functions in addition to contributing equipment to the hospital itself. Their latest achievement has been the building of a beautiful chapel on the bridgeway connecting the old hospital with the new.

February Meeting

A busy month was reported when the ladies' auxiliary of Hotel Dieu of St. Joseph, Chatham, N.B., held its February meeting. The convener of the gift shop committee stated that business had been booming.

Forty-eight sheets and 18 towels had been made for Mount St. Joseph Hospital, also in Chatham, and 36 baby blankets were supplied to Hotel Dieu. The final plans were made for a card party.

When the business session had ended, refreshments were served by the Reverend Sisters.

Auxiliary Helps Equip Section

The women's auxiliary of the Toronto East General and Orthopaedic Hospital, Toronto, recently presented a cheque for $10,000 to provide and equip a special 20-bed section of the obstetrical department in a converted area of the hospital. The new section will include an isolation nursery, an infant examining room and a student nurse classroom. Another of this auxiliary's past projects has been contributing funds to the newly formed social service department. This department has given much service to the community and to indigent patients by supplying layettes for new babies' clothing and food for many needy patients, visits and other services for elderly people, and taxi fare for patients who would otherwise be unable to attend clinics.

Auxiliary Work with the Deaf

The president of the Toronto women's auxiliary to the Canadian Hearing Society recently announced that with the bequest of the late Helen McMurrich, the auxiliary hopes to extend service to elderly deaf persons and consider the possibility of enlarging the work done for the deaf child. It was reported by the children's work committee that the outings for children in the hard of hearing classes were so successful that each of the six classes will be given a day in the country starting in June this year. As well as raising $2,181 through a sale at one of the member's homes, 68 hearing aids were purchased during 1959.

Hospital Receives Guild Gift

More than $9,000 was turned over to the Children's Hospital, Winnipeg, Manitoba, by the St. Agnes Guild according to the January report. All funds will go towards research projects. Besides the guild shop program other major money-raising projects were a coffee party and rummage sale. This guild is now in its 50th year of operation.

New Auxiliary's Activities

The Wellesley hospital, officially separated now from the Toronto General, has received from its mother auxiliary the Gift Shop started at the Wellesley Hospital four years ago, as well as the two mobile carts with stock. In addition the Toronto General auxiliary is donating $1,000 to help set up the new organization. Now consisting of 90 members, membership is open in the Wellesley auxiliary to anyone interested in auxiliary work.

New Coffee Shop

A new coffee shop financed by the auxiliary of Grace Hospital, Windsor, Ontario, opened January 27. Space was made available for the shop in the basement of the north wing and the auxiliary has worked on the plans since early last fall. A member of the auxiliary will be in charge with all members lending a hand at various times.

Great men never feel great; small men never feel small.—*Chinese Proverb.*

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Provincial Notes

British Columbia

In Esquimalt a 45-bed private hospital is to be opened—the West Bay Private Hospital. Renovations costing $50,000 have been carried out by the owners Mrs. A. C. Wurtele and Mrs. Graeme, R.N. Contractors for renovations were Young and Thuillier.

St. Joseph's Hospital at Victoria has been granted $125,000 by the City council for its building fund for a new wing.

An 18-acre country estate on Blenkinsop St. in Victoria is to be used as a treatment centre for emotionally disturbed boys. It was handed over to the Family and Children's Service by the B.C. Foundation for Child Care, Poliomyelitis and Rehabilitation.

The Vancouver General Hospital has a new-type incinerator which not only disposes of all the hospital's waste but eliminates smoke and fly ash. The waste disposal process cuts out obnoxious gases and leaves only sterile ash. In recognition the hospital received a citation from the Air Pollution Control Society.

Alberta

Extension of facilities in the chronic hospital area is urgently required. Construction of Grande Prairie's $375,000, 50-bed chronic hospital is to be commenced shortly. It is expected to take 18 months to complete. The building, to be in the shape of a cross, has been designed by Edmonton architects, Blais, Sheddon and Associates. Also the Willow Creek Hospital for the chronically ill in Claresholm is to have an 18-bed addition, bringing the capacity up to 50 beds.

Approval has been received for extensions and alterations in many hospitals. The Mannville Municipal Hospital has had plans approved to the extent of $90,000, with work to commence in the spring. A further grant for some $90,000 has also been approved for a 15-bed addition to Drayton Valley Municipal Hospital.

New hospitals have also received approval. A $1,000,000 "auxiliary" hospital unit to serve Lethbridge and district will probably be used for long-term patients. Locations for the new 100-bed hospital are being considered.

Hon. J. D. Ross, M.D., Minister of Health, has approved plans for a 25-bed hospital to be built at Stony Plain—the cost of the project is limited to $250,000, the amount the provincial government will provide.

Tenders will be called early this spring for the new $9,000,000, 600-bed Royal Alexandra Hospital in Edmonton. Architects for the project are Rule, Wynn and Rule, Edmonton. Tenders will also be called for the St. Theresa Hospital project at St. Paul. This project is estimated at $1,000,000 and is designed by Diamond, Clarke and Associates of Edmonton. The Calgary General Hospital Board is receiving tenders for a 200-bed convalescent wing estimated at $2,000,000. The architects are J. Stevenson and Associates of Calgary.

N. W. Territories

It is reported that the Mackenzie District will come under the National Hospital Insurance scheme next April. The scheme as at present proposed will give ward care to people in the area for $1.50 a day. No premiums are to be charged due to the difficulties encountered in collecting such sums in widely scattered communities. Financing will be partly effected through a fuel oil tax and an increase in the price of liquor. The scheme will pay hospital expenses for any citizen of the NWT who has established the proper three month term of residence. Cost of hospitalization for natives has been one of the stumbling blocks delaying the entrance of this district into the insurance plan. Under the present plan the Northern Health Services branch will pay the required ward rate for these people.

Saskatchewan

Plans are being studied for a $9,500,000 addition to the Regina General Hospital—this would bring the hospital's capacity up to 1,000 beds. Nothing however will be decided until the hospital board has investigated the whole problem. Regarding finance, there is a possibility that the extension could receive additional provincial government support beyond normal grants. The extension would be carried out in stages—one five-storey wing, followed by another later. The only major alterations will be to the Alexandra Regina unit of the existing buildings.

Tenders are expected to be called for renovations to the existing west wing and the remodelling of the maternity and isolation wards of the Saskatoon City Hospital. Architect for the project is Frank J. Martin.

Manitoba

The new addition to the Ericsson Medical Nursing Unit, Ericsson, officially took place last November. The addition to the hospital consists of a new ramp-emergency entrance, four new wards, three bathrooms, with an emergency or casualty room and service room. In addition there is a new heating system, a clinic room and laboratory, four nurses' rooms for living quarters and a new sitting room.

It is reported that services provided by nine nursing stations in remote areas of Manitoba and by the Berens River nursing station operated by the Grey Nuns, have been brought under the wing of the Manitoba Hospital Services Plan. This will provide prepaid care at these facilities—often the only services available in the areas. Formerly these stations were operated by the Indian Health Services branch of the national Department of Health and Welfare and each station was staffed by two registered nurses with communication maintained by means of radio-telephone. The stations are primarily equipped to provide out-patient care and public health instruction.

Ontario

A $250,000 anonymous donation has been made to the Toronto General Hospital, Toronto. It is to be used at the discretion of the board of trustees.

The proposed addition to the Bethesda Hospital, 325 Sheppard Avenue West, Toronto, will cost an estimated $1,800,000. The new hospital is to be five floors, with 115 beds providing out-patient and emergency wards, a paediatric ward, a surgical ward, an obstetrical ward and a medical ward, with

provision for future expansion to 350 beds. Architects for the proposed hospital are the firm of Deacon, Arnett and Murray, Agincourt.

The east wing of the Brockville General Hospital, Brockville, was officially opened the end of November. The new section makes available 60 new beds—30 for chronic patients on the first floor—and 30 for surgical patients on the second floor.

The completion of a quarter million dollar renovation program to the old section of the Smiths Falls Public Hospital, Smiths Falls, completes the hospital's construction project. Twenty-six additional beds have been provided by the renovation, of which 12 are medical and surgical and the remainder are for obstetrical cases. The "new" second floor will be used for maternity cases and all necessary facilities have been supplied.

The Huron Construction Co. Ltd., Chatham, has been awarded the general contract for the unfinished areas for the Public General Hospital, Chatham. The architects are Govan, Ferguson, Lindsay, Kaminker, Langley & Keenleyside, Toronto.

The new addition to the North York Branson Hospital, Toronto, was officially opened early in December. The bed capacity has been raised to 163, a new and enlarged x-ray department has been organized and a complete paediatric ward supplied in the expansion area. Four new nurseries have been added to the maternity department. A school of nursing has been established and the construction of a student residence with classrooms has commenced. In addition, the hospital's architects, Jackson, Ypes and Associates have been instructed to prepare plans for the next expansion which will give a total of 275 beds.

Tenders have been called for the construction of an addition and alterations to the existing building of the Peel Memorial Hospital, Brampton. The architects are Govan, Ferguson, Lindsay, Kaminker, Langley, Keenleyside, Toronto.

The general contract for additions to the Hotel Dieu Hospital, Kingston, has been awarded to T. A. Andre & Sons Ltd., Kingston. Work has started on the hospital, owned by the Religious Hospitalers of the Hotel Dieu. The total estimate is $4,200,000. The architects are Drever & Smith, Kingston, with Agnew, Peckham & Associates, Toronto, as hospital consultants.

Tenders have been called for the construction of a 300-bed wing for the Westminster Hospital (D.V.A.), London. The architects are Blackwell & Hagarty, London.

One of the three new additions to the Ontario Hospital at Hamilton was to be completed by the end of December. In the large cross-shaped structure one wing forms the administration centre, the second wing is tipped by the circular cafeteria building, and the other two wings contain the reception and acute treatment wards with 200 beds. The keynote to the new building is the wide open interior space, light, air and colour—in strong contrast to the prison like atmosphere of many mental hospitals. Protection is provided by armour glass and steel screens rather than iron bars. The mental health clinic, a small separate building, and the 400-bed geriatric building featuring an apparent lack of restriction in its "spread-H" layout, balconies and gardens, are to be finished by June.

The Fred Adams' Hospital at Windsor has been turned over to the Metropolitan General Hospital and will be opened as a wing of that hospital.

Employees and staff members of the Sudbury General Hospital have formed their own credit union. This new credit union has a potential membership of 500 and is chartered by the Province of Ontario.

In Spring the $4,000,000 new area hospital for Welland will be opened. It will be the most modern of its kind in any of the non-metropolitan cities of Canada.

Further hospital expansion is planned for North York, this time a sixth general hospital to contain 200 beds. It will also contain a psychiatric ward and mental health out-patient clinic. It is to be named the York General Hospital and will be built at Playfair and Dufferin Streets.

The St. Joseph's Hospital at Hamilton has named three McMaster University nuclear scientists to its medical staff on equal basis with members holding medical degrees.

Quebec

Renovations and alterations are to be carried out in many hospitals. The Hôpital Notre Dame de l'Esperance in St. Laurent is to have a new six-storey, $2,800,000 wing covering 124,000 sq. ft. The new wing will add 165 beds and 60 bassinettes to the present 129 beds. There will also be room to add the new services for maternity, paediatrics and gynaecology. A public subscription campaign will be launched in May to help raise $950,000 of the total. It is expected that federal and provincial grants will provide the balance.

The federal government has transferred the Hôpital Parc Savard in Quebec City to the Province of Quebec. The hospital is now under the management of La Corporation de l'Hopital du Christ-Roi, Parc Savard. The contract for renovations in excess of $500,000 has been awarded to Adrien Hebert of Quebec. Architect for the project is Germain Chabot.

Renovations and expansions at St. Mary's Memorial Hospital of Montreal have been completed. At a cost of about $2,800,000 over a period of three years 73 beds and other treatment and teaching facilities have been added.

Work has begun on the 100-bed hospital in Lac Megantic. The new hospital is to have six storeys at an estimated cost of $2,000,000. Architect is Albert Poulin.

Under construction also is a 155-bed addition to Hôpital St-Joseph at Lac Megantic. The architect is, again, Albert Poulin of Sherbrooke.

Work has also been commenced on the estimated $1,500,000 hospital in Amqui. Architect for this project is Maurice Mainguy of Quebec.

A new private hospital for convalescents was opened at Sainte-Julienne in January. It is to be administered by Garde Solange Légaré.

The contract has been awarded for the construction of a 100-bed hospital at Magog to replace the present Hôpital de la Providence which is badly overcrowded. The old building is to be used as a home for the aged. Designed by Albert Poulin, the new six-storey hospital is to cost an estimated two and a quarter million dollars.

The Royal Edward Laurentian Hospital in Montreal has celebrated its 50th anniversary. Hospital officials and many citizens recall its opening in October 1909. King Edward VII pulled an electric switch in England which opened the doors, raised the Royal Standard and turned on all the lights in the old Royal Edward Institute.

Dufresne and Boulva, Montreal, have drawn up the plans for a 9-

There is a difference

At first glance these two insects appear to be identical. Actually, the bug on the left is the fearsome Indian carpenter bee, while its "twin" is a harmless housefly. This similarity in appearance protects the fly from its natural enemies and permits it to live its life in peace.

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bed hospital, l'Hôpital Notre Dame de Hull, Hull, Que. The three-storey building will contain three surgical suites, a large laboratory and other essential services such as radiography, pharmacy, and emergency department. "Une belle acquisition pour la ville", exclaimed the mayor when he saw the model of the new hospital.

The new Hôpital St. Charles de Joliette, Joliette, has been officially opened. The hospital, which will accommodate 1,500 mentally ill patients, was built at a cost of $15,000,000.

A vigorous fund-raising campaign is under way to provide a new hospital—l'Hôpital Le Gardeur — for Repentigny. The proposed structure is to have 56 beds for adults, 26 for children.

Contractor for a new $1,500,000 hospital on the road to Brownsburg near Lachute is M. Albert D'Amours. So far $300,000 has been spent on the project.

Tenders are being called for extension to the nurses' residence of the Verdun General Hospital at Montreal. It is to be a 3-storey concrete structure. The new building is designed by Fleming and Smith.

Coming Conventions

March 14 - 18 —Laundry Institute, Saskatoon, Sask.*

March 21 - 25 — Laundry Institute, Winnipeg, Man.*

March 28 - April 1—Housekeeping Institute, Edmonton, Alta.*

April 25-30—Third International Congress on Medical Records, Edinburgh, Scotland.

May 9 - 12—O.H.A. - A.C.H.A. Second Basic Institute for Hospital Administrators, Park Plaza Hotel, Toronto, Ont.

May 23 - 25 — Canadian Hospital Association Assembly Meeting, Park Plaza Hotel, Toronto, Ontario.

May 30 - June 2—Catholic Hospital Association of the United States, annual convention, Milwaukee, Wis.

June 12-16—The Canadian Society of Laboratory Technologists, 24th national convention and annual meeting, Sheraton-Mt. Royal Hotel, Montreal, Que.

June 13-17—Canadian Medical Association, Annual Meeting, Banff, Alta.

June 13 - 17—Canadian Society of Radiological Technicians, 18th convention, Macdonald Hotel, Edmonton, Alta.

June 19-24—Canadian Nurses' Association, biennial meeting, Nova Scotian Hotel, Halifax, N.S.

June 22-25—Canadian Physiotherapy Association, annual convention, Vancouver, B.C.

June 27-29—Comité des Hôpitaux du Québec, annual convention, Provincial Exhibition Grounds, Quebec City, Que.

Aug. 28 - Sept. 2—International Society for the Welfare of Cripples, Eighth World Congress, Waldorf-Astoria, New York.

Aug. 29 - Sept. 1—American Hospital Association convention, San Francisco, California.

Sept. 6-9—Western Canada Institute for Hospital Administrators and Trustees, Queen Elizabeth Auditorium, Vancouver, B.C.

Sept. 20-21—Catholic Hospital Conference of Alberta, 17th annual meeting, Jubilee Auditorium, Edmonton, Alta.

Oct. 10-14—American College of Surgeons, 46th Annual Clinical Congress, San Francisco, Calif.

Oct. 12-14—Saskatchewan Hospital Association, annual meeting and convention, The Bessborough Hotel, Saskatoon, Sask.

Oct. 18-20—Manitoba Hospital and Nursing Conference, Winnipeg.

Oct. 24-26—Ontario Hospital Association, annual convention, Royal York Hotel, Toronto, Ont.

***Institutes on laundry and housekeeping administration have been planned by the Canadian Hospital Association in co-operation with western provinces.**

The Fraser Research Laboratories in the women's pavilion of the Royal Victoria Hospital at Montreal have been opened.

New Brunswick

The Moncton Tuberculosis X-ray Clinic has moved into more spacious quarters formerly used as a residence for the medical superintendent of the Tuberculosis Hospital. Previously the clinic occupied one small section of the hospital building. Renovations at the former Tuberculosis Hospital are now almost completed. It is to be the Moncton Hospital Annex and will have a capacity of 75 patients. The Annex has already received its first patients.

A new wing of the Victoria Public Hospital at Fredericton has been opened. Construction began in September of 1958. The wing will eventually have 97 additional beds. It has been in partial operation for the past few months. Total cost of the wing, including equipment, is $550,000.

Prince Edward Island

Construction on the extension to the Western Hospital at Alberton will be resumed this month after having been suspended for the winter. At present the basement of the extension is completed. The unit will contain a total of 46 rooms including two operating rooms, delivery rooms, out-patient, laboratory and x-ray.

New Skull Positioning Apparatus

R. K. Travis, a graduate of the Canadian Hospital Association's extension course in hospital organization and management, has perfected a new skull positioning apparatus to help in skull radiography. Mr. Travis has studied radiography at the Toronto General Hospital and the Hospital for Sick Children, Toronto, Ont., and has been technical adviser in the department of radiography at the Kingston General Hospital, Kingston, Ont.

The patient's head can now be carefully positioned in comfortable polyurethane foam inserts. In the past his head rested on the hard table top, at times being held in position by uncomfortable clamps. The radiologist will benefit from this invention too. All the necessary views of the skull are accurate because of this new apparatus.

Graduate Education

(concluded from page 72)

to outline the emergence in the health field of graduates of the University of Toronto program in hospital administration. The variety of administrative positions held currently and throughout the past decade is convincing evidence that the program's aims are being realized. Equally impressive is the rapidity with which the members of this new trained administrative group have moved toward and into senior executive posts both within and outside of hospitals.

Estimation of the probable future influence of graduates of the Canadian programs upon the Canadian hospital and health field constitutes the theme of another study now being carried out. In respect to this theme, reference may be made to a recent analysis of hospital and graduate data by Richard Johnson* in an attempt to measure the present and probable future penetration of the hospital field by graduates of the several programs. Significant in Johnson's study were the *following* findings: by actual count there were in 1958, 735 graduates of a total of over 2,600 serving as administrators in listed hospitals (total: 6,900) in Canada and the United States, representing 10.7 per cent of the available positions. By projecting 1940, 1948 and 1958 data, estimates of 1,750 administrator - graduates by 1970 and 3,500 by 1980 were obtained. Since Canadian data for hospitals and graduates should not be dissimilar, proportionally, to those representing the continent, the future picture of the influence of Canadian graduates may be expected to be as promising as that outlined by Johnson's calculations.

As a consequence of the establishment of hospital care insurance plans under public auspices throughout Canada, a probable development in the coming years will be the employment of an increasing number of graduates by health departments at both the provincial and federal levels of government. This development was initiated by those provinces now having well-established hospital care insurance programs and may well be expected to be adopted by those provinces now entering the compulsory care insurance field. The contributions to the maintenance and improvement of hospital standards made by the consultant-graduates in the first-named provinces makes this development a thoroughly logical one in the future. ■

*Richard L. Johnson, "The Influence of Graduate Programs in Hospital Administration on the Hospital Field", **Graduate Education for Hospital Administration,** Ray E. Brown, Editor, Proceedings of a National Symposium held at the University of Chicago, December 10-13, 1958; The Graduate Program in Hospital Administration, University of Chicago, 1959.

Mental Health

The study is now under way at Graylingwell Mental Hospital in England to discover whether the provision of large-scale psychiatric treatment on an out-patient basis can materially affect the great annual increase of admissions to mental hospitals. This service is centred on a day hospital providing active treatment for 20 to 30 patients, with a staff of three psychiatrists, occupational therapists, psychiatric social workers, an almoner and nurses. It is claimed that, as a result of its work, there has been a reduction of 56 per cent in the number of patients admitted to the local mental hospital in one year.—*WHO Chronicle, July-August, 1959.*

Book Reviews

NUTRITION FOR TODAY, by Elizabeth Chant Robertson, M.D., Ph.D. Published by McClelland and Stewart Limited, Toronto, 1959. Pp. 259. Price $2.95.

This very interesting book is about food — in all its fascinating forms. Fruits and vegetables, cereals, milk and milk products, meat, fish and poultry, eggs, fats, sugar, salt and water, as well as the necessary food elements they contain, are discussed and analyzed. The author then gives advice on how to cook these foods so that all their value will not be lost.

Chapters on related subjects such as calories, diets, meal planning, economical buying, school day lunches, food facts and fancies and so on help complete the story. Nurses, teachers, medical students and housewives will like this book and find it useful.

DIABETIC MANUAL, by Elliott P. Joslin, M.D., Sc.D. Published by Lea and Febiger, Philadelphia 1959. In Canada by The Macmillan Company of Canada Limited, Toronto, Tenth edition. Pp. 304. Price $3.75.

The author is convinced that diabetes is a formidable enemy, one that must be met—and controlled—by the best weapons science offers. He emphasizes the importance of a close relationship between the patient and his doctor. Only in this way can the serious effects of the disease be conquered, he feels.

The book is written primarily for the diabetic patient. It offers him advice on how to arrange his life for better health and happier days.

ASEPTIC TECHNIQUE FOR OPERATING ROOM PERSONNEL, by Feline Webb Perkins, R.N.,B.S. in N.Ed. and M.S. in N.Ed. Published by the W. B. Saunders Company, Philadelphia and London, 1959. Pp. 172. Price $2.00.

In 1955 the Committee on Practical Nursing of the Virginia League for Nursing set out to discover what special courses for practical nurses were really needed and wanted. The survey revealed that the subject to concentrate on was operating room technique and so plans for a course were made. This manual evolved from the program. It outlines clearly and concisely the technical skills which are demanded in the operating room.

Thus the manual gives students the necessary basic knowledge. But its value is not limited to this. It can also serve as a guide for instructors who want to set up courses in operating room technique.

THE PRACTICAL NURSE: Textbook of Nursing. By Kathryn Osmond Brownell, R.N., B.S. and Vivian M. Culver, R.N., B.Ed., M.Ed. Published by the W. B. Saunders Company, Philadelphia and London, 1959. Pp. 899. Illus. Price $6.00.

This fourteen unit textbook is focussed on the well-being of the patient and the rôle of the practical nurse in unison with, and under the supervision of, professional personnel. The first three units serve to orient the student to being a student, to practical nursing and to the broad aspects of health. The text continues with the basic principles of body structure, the prevention and control of illness, nutrition, and administration and action of drugs. The fundamental principles of nursing care are followed by the specific needs of patients in the areas of maternal and child health, medical and surgical illness, the elderly and the mentally ill. Care of the aged, nursing in the home, and nursing in emergencies and disasters are also included.

To administrators and teachers in this field this text provides an excellent guide and up-to-date view of practical nursing within the broad context of nursing.

SPEECH AND BRAIN-MECHANISMS, by Wilder Penfield and Lamar Roberts. Published by Princeton University Press, Princeton, N.J. In Canada, by S. J. Reginald Saunders and Company Limited, Toronto, 1959. Illus. Pp. 286. Price $6.00.

This book is the result of ten years' study of the neurological mechanisms of speech. Consideration is given to aphasia and other speech disturbances, brain dominance and the evidence for localization in the dominant hemisphere. The authors summarize the functional anatomy of the human brain and the recent physiological conclusions derived from electrical stimulation of the cerebral cortex. They then discuss hypotheses of verbal memory and conceptual memory and the the mechanisms of the brain that form the cerebral basis of consciousness. The final chapter deals with the learning of languages.

There is also a section devoted to case studies of cortical excision and a new method of mapping the limits of the cortical speech areas by electrical interference.

"Hypothetical reasoning must always wait on the tests of time", say the authors. "And if, in the end, our hypotheses are found wanting, they should serve nonetheless to guide other explorers who pass this way."

WORKBOOK FOR PRACTICAL NURSES by Audrey Latshaw Sutton, R.N. Published by the W. B. Saunders Co., Philadelphia, Pa., 1959. Price $3.50. Illus. Pp. 347.

This is a practical workbook, designed to simplify learning processes, while emphasizing those areas which are of peculiar importance to the practical nurse. It includes references, situation problems to be used in classroom discussions, and assignments for home study. Parts I through V are intended for use in the preclinical training period, including a review of arithmetic. Parts VI through VIII are intended for use in the clinical training program. This includes vocabulary exercises, disease conditions, an anatomy and physiology review, and a discussion of diagnostic procedures, medical and surgical treatment and general nursing care including diet and drug therapy.

BASIC MEDICAL-SURGICAL NURSING, by Mildred A. Mason, R.N., B.S. Published by the Macmillan Company, New York. In Canada by Brett-Macmillan Ltd., Galt, Ont. Pp. 513. Price $4.95.

This book, written as a textbook for the licensed practical nurse is divided into 11 parts. Part I gives background information, Part II tells the nurse how to look after the patient with a general disease condition, and Parts III through XI explain the rôle of the practical nurse in caring for the patient with one of the more common diseases of a system of his body. Each part is interrelated with preceding and subsequent discussions.

(concluded from page 46)

the intervening years in providing constructive activity for the children during long, lonely, and sometimes fearful hours. It is interesting to note that it is well to include some of the juvenile classics and other old favorites in the adults' library—they do like to reminisce at times!

May I quote Margaret N. Kinney who wrote, "Bibliotherapy as practised by most librarians in hospitals may be considered nothing more than good library service, which strives to take into consideration the individual differences of the patients, including the factor which has resulted in their hospitalization. Such library service, whether or not it extends into the field of bibliotherapy, as such, makes a recognized contribution towards the well-being of the individual. It should not be forgotten that the influence of reading as recreation, to bolster morale, and as a social aid, is also a part of bibliotherapy".

The works of mercy are corporal as well as spiritual; Christ ministered to man's physical as well as his spiritual needs. Once we are committed to the service of Christ's beloved sick, we are forever committed to a total ministration in His Name. Librarians (and this includes all engaged in such service) are key people in the apostolate of the sick, although it may not always be easy to obtain proper understanding and co-operation — and it is possible that even library people are sometimes not sufficiently aware of the value and the beauty of their work. But this does not minimize its importance. And if we claim to serve in the name of Christ, do we wish to offer any but the best in personnel or in service? It is well, too, for us to remember the words of Cardinal Newman: "Nothing would be done at all if a man waited until he could do it so well that no one would find fault with it".

The title given this article is "Why a Library?" Through reading, study, discussion, and experience, I am so convinced of its necessity that when I meet anyone from an institution where reading service is not yet organized, I am tempted to say, "What—no library!!"—and then consider that, perhaps, like ourselves, it is taking them a while to get around to it!

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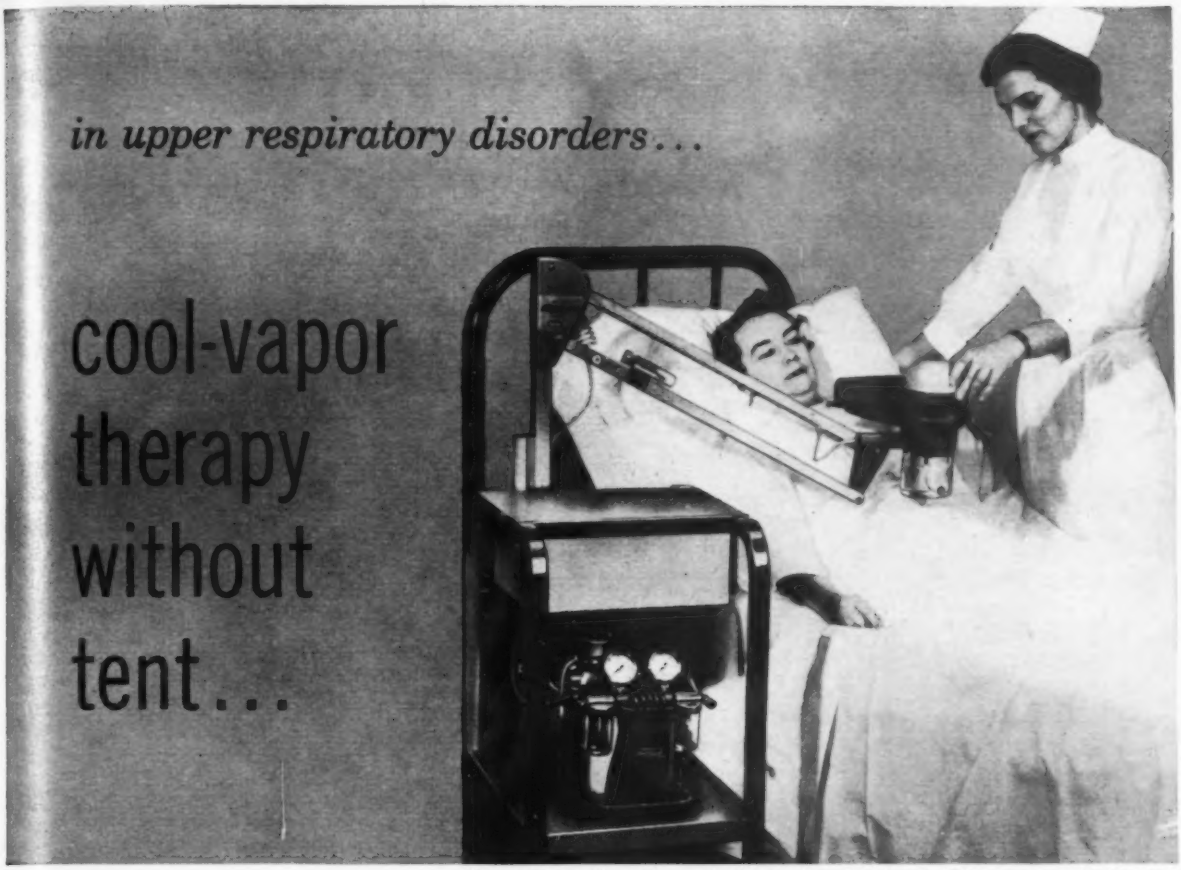

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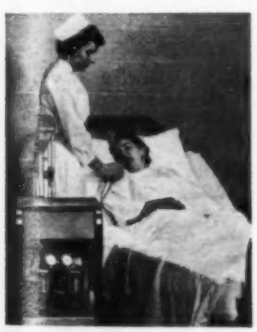

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1. Ranger, I. and O'Grady, F.: Lancet 2:299, 1958.

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The Volunteer

(concluded from page 52)

There is unlimited opportunity for volunteer services in the community. The development of ex-patients' clubs suggests the probability of using volunteers in sponsoring opportunities for resocialization and rehabilitation programs that will benefit those referred. The same is true of sheltered workshops, the half-way house, and other community-based services.

There are still unexplored opportunities for use of the friendly visitor or the helping hand as an integral part of follow up services. A corps of volunteers might be organized and widely deployed throughout a district covered by a social worker or public health nurse. They would report their activities and their findings to her, always bringing to the attention of the professional person matters which interest or vex them about the behaviour of the ex-patients they have visited. Friendly visitors may be assigned to chronic patients who have returned home or convalescents who need a helping hand because they find picking up the thread of responsibility difficult and homemaking taxing. Finding a job is no simple matter for the recipient and the understanding help of the volunteer may be vitally important, since the volunteer may represent labour or management, employee or employer, debtor or creditor, and may even be a fully recovered ex-patient himself.

Recognition and Planning

Satisfaction may be reward enough for some. Encouragement and expressions of appreciation from those served and from professional staff in the mental health facilities are gratifying to most volunteers. Many find the personal growth and self improvement that result from their investment very rewarding. Others find more demanding assignments stimulating and ego-satisfying. It is still worth our time to give some attention to certain methods of according recognition to those who give their time, energies and talents to volunteer services.

When certificates are given for a year's service, plaques for five years' service, et cetera, these are often awarded at annual meetings of the mental health facility or mental health association. These annual meetings or testimonial dinners attract publicity, not only for the volunteers so recognized but for the volunteer program as well. This may well bring inquiries about the program and new recruits. And so, full circle—although nothing takes the place of the volunteers' own word-of-mouth contact with friends and neighbours.

Careful planning for volunteer services is essential. Top-level support is a *sine qua non* factor. The project for volunteers must be realistic in terms of the numbers of volunteers available, the aptitudes of volunteers, the time volunteers are prepared to devote, the readiness of the mental health facility to provide training and supervision.

Volunteers demand the regular staff's time. The extent to which regular staff are prepared to meet this need is in itself recognition of the importance we attach to volunteer services. Some mental health facilities have prepared manuals for volunteers. No manual takes the place of personal attention. But the preparation of such material, even if modest in scope, constitutes an important investment of staff time in planning for volunteers and a commitment to the volunteer program. ■

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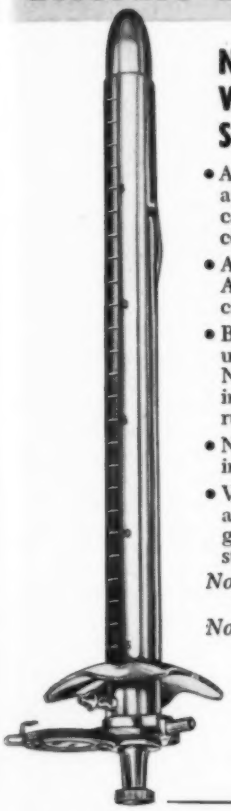

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(continued from page 60)

wonder that young men and women considering their life work may find that there are shorter and easier ways to successful careers where the current hypertrophy of the critical spirit is less destructive in its application? The fact that the medical profession is not composed entirely of Oslers, Farquharsons, Schweitzers, Levines and Slees as well as others I could mention, should come as no surprise to hospital administrators.

If the Professional Activities Study techniques and/or accurate medical audits can come up with some reasonable answers as to what determines good but not excessive medical and hospital services, our profession and society in general will benefit greatly. But these should be developed for our own needs in our own Saskatchewan community. What happens in Michigan or in the United Kingdom or in any other parts of Canada, although important and perhaps serving as desirable goals or guide posts, nevertheless cannot be the whole answer to our peculiar problems.

No one can really tell what the future holds for the health field. All we can hope is that the medical profession and the hospitals, as they are further Douglasized or perhaps Thatcherized, are not pulverized to the point where sufficient personnel or the desire for the first rate is jeopardized. If this happens, and some think this is a real threat, evaluation techniques and medical audits may show over the years a dismal recital of deterioration in over-all health care.

Finally, in spite of all the high powered scientific work of an analytical, research or service variety, high quality care can be threatened by another danger which is difficult to tabulate by any of our electronic computers and which cannot be measured in any cyclotron. Indeed, it involves all hospital workers in all fields, whether they be doctors, nurses or any of the paramedical personnel.

This problem has been well expressed by a recent editorial in the *New England Medical Journal*[21]. Commenting on the plan to develop a new wing at the Peter Bent Brigham Hospital in Boston, one of the finest of the hospitals in the United States, the editor says, "As material wealth increases and hospital after hospital erects more stately mansions for the housing of its multiple activities, the smaller needs of the individual patient must not be buried beneath the avalanche of spectacular techniques that are being devised for the study and treatment of disease. A general increase in personnel in all hospitals has been accompanied by a falling off in many of the minor skills and medical and nursing attentions that point up the fundamentally humanitarian character of the care of the sick. Without such a demonstration of basic charity, faith and hope may lose some of their meaning."

The type of care that this editor hopes to preserve may be difficult indeed to measure on the basis of any evaluation techniques, but this does not mean that it is not of prime importance. No matter how well we may complete records and publish statistics, man is not after all a statistic, a point on a scatter graph or even a fly speck on a lantern slide filled with obscure mathematical data.

(concluded on page 92)

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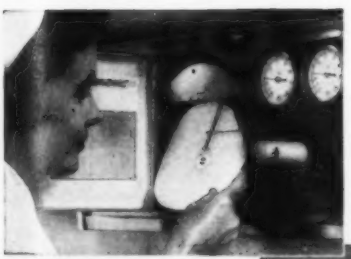

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Evaluation

(concluded from page 90)

Caring for the patient in the sense expressed by Dr. Peabody[22] means the application of principles of love and charity, so well expressed in the thirteenth chapter of First Corinthians. All health workers need to apply these principles, not only to their patients, but to their colleagues and lastly, and perhaps equally important, to themselves.

Until educators in the health field and students, either of undergraduate or postgraduate status, are prepared to accept and apply the truths contained in the Books of Job and Corinthians with as much enthusiasm as those contained in the books of Boyd; and to have the same reverence for the applied philosophy of a Schweitzer and for that contained in the classic prayer of St. Francis of Assisi as they do for electrolyte imbalances and cardio-renal pathophysiology; then all our retrospective analyses of scientific facts, no matter how well done and no matter how well applied, will leave our patients unsatisfied.

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Legislation

(concluded from page 49)

The history of legislation governing admission of patients to mental hospitals discloses a trend toward the liberalizing of these procedures. For example, in Ontario before 1935 it was usually necessary to certify that a patient was "insane and dangerous to be at large" in order that the patient be admitted to a mental hospital. Current certificates are to the effect that the person is "mentally ill." Many patients are admitted upon their own request.

The "open door" policy is receiving increasing application in mental hospitals with a resulting tendency to minimize the custodial aspects of mental hospital care. Increasing use is being made of the facilities of general hospitals. These developments may result in further alteration in the legislation governing the treatment of mentally ill people.

The objective is to strike a reasonable balance between the liberty of the individual patient on the one hand and the removal of unnecessarily cumbersome and restrictive admission procedures on the other hand.

A comparison of the legislation in Canada at the present time indicates that our statutes are as advanced as those which prevail elsewhere.

The foregoing is a list of some of the problems which are met with in psychiatric practice, some of which are difficult to solve. Legislative action may be required to assist in the solution. In some cases the legislative action would be a matter for the federal government and in other cases the subject is within provincial jurisdiction. All that is attempted here is a statement of the problem in the hope that ultimately a satisfactory resolution will be secured. ■

Research Institute

(concluded from page 50)

before the other wards are opened. The second building will be taken over in about one year and the entire property in 1962. The development of this institute in conjunction with a small hospital school on the site will probably be in the planning for the future. Then the great need for more beds for the mentally retarded and the desire for a hospital school with university affiliation could to some degree be met. ■

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4. Never say "No!" to a request.
5. Accept all invitations to meetings, banquets and committees.
6. Do not eat a relaxing meal—plan a conference for the meal hour.
7. Fishing and hunting are a waste of time. You never bring back enough fish or game to justify the expense.
8. It is poor policy to take all the vacation time which is provided to you.
9. Golf, bowling, billiards, cards and gardening are a waste of time.
10. Never delegate responsibility to others. Carry the load at all times.
11. If your work calls for travelling, work all day and drive all night for your appointment next morning.

Follow these rules faithfully and you'll soon be a member of the Coronary Club, the Foundation says. However, they hope that some people will take the hint.—*W.C.H. News Bulletin.*

Fund Raising Organizations

Secretary Managers

(concluded from page 47)

The preparation of a course for secretary managers is not an easy task. It requires careful planning and financing. It is felt that such a course for secretary managers of small hospitals should give rather more detailed information than present courses in hospital administration. By the same token, the course will contain less background material and will not be at as high an academic plane as other courses now in existence. Because of the amount of work involved and the very considerable expense that may be encountered, we would suggest that the new course being developed in Saskatchewan be watched very carefully by those in other provinces. One of the best ways of doing this would be to send some students to participate.

Until we have a year or two of experience, we shall not be in a position to make specific recommendations. At the end of a trial period, it will be possible to decide, first, whether this type of course is worthwhile; second, whether the Saskatchewan course will be sufficient to cover one province or many. It would not be wise to have unnecessary duplication. On the other hand, it may prove to be necessary and practical to develop similar courses in each province or in each provincial area; *i.e.*, Maritimes, Quebec, Ontario, and Western.

The correspondence course, "Administration for Small Hospitals", is designed as a final link in the levels of training now offered by other organizations. We believe that it should in no way replace formal university training for those who seek a career in hospital administration — where it is possible to secure such university education. It is further our belief that administrators of somewhat larger hospitals, who cannot take a university course, should prepare themselves by taking the course in hospital organization and management offered by the Canadian Hospital Association. If desirable, they might take the course, "Administration for Small Hospitals", prior to enrolling in the C.H.A. course. This new course for administrators of small hospitals is specifically designed as a practical course for those who are engaged in the operation of small hospitals, particularly those hospitals which are of less than 50-bed capacity. The course is still an experiment, but an experiment which we hope will close the last educational gap in the field of hospital administration. ■

C.S.R.T. Convention

The eighteenth annual convention of the Canadian Society of Radiological Technicians will be held in Edmonton, Alta., June 13 through 17, 1960. Refresher courses have been planned to interest technicians in all aspects of radiography and therapy. One of these, given by Percy Hunt, will be on general hospital administration, with some special emphasis on the department of radiology.

A prize of $100 will again be offered for the best essay paper presented by an R.T. at the convention. The George Reason Cup will be awarded for the best exhibit.

And, following the convention, there will be a trip through the mountains in Jasper and Banff.

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A.C.H.A. Activities

The Second Basic Institute for Hospital Administrators will be held at the Park Plaza Hotel between May 9-12, according to word from Stanley W. Martin, executive secretary-treasurer of the Ontario Hospital Association. The O.H.A. and the A.C.H.A. are working together in the preparation of the program for the Institute.

Among the topics under consideration are these: an examination of the specific techniques that are available for evaluating patient care; requisites of a plan for emergency and disaster planning, with emphasis on the rôle of the hospital in present federal/provincial health service emergency planning; and a review of ways by which efficiency in the hospital can be implemented. Also to be studied at the Institute are: trends in hospital care, an examination of progressive methods currently functioning with some success; accreditation, what it means and what the present needs appear to be; collective bargaining, the "hows" of this important operation; trends in hospital construction, latest developments in the field; and the hospital and the community, a survey of the hospital's responsibility for planning and participating in community health services. The program of the Institute will include both formal and informal lectures, as well as group discussions.

On May 13, the College will conduct examinations for nominees seeking advancement to the status of membership. Max B. Wallace, general superintendent of the Toronto Western Hospital and Regent of the College, will work with A.C.H.A. assistant director Alfred Van Horn III in supervising the examinations.

Mr. Wallace advises all nominees who are eligible for advancement but who have not filled in application forms to request them immediately from the American College of Hospital Administrators so that they can be processed in time for the Canadian examinations.

Did You Know?

In India artificial rice is being produced from a mixture of tapioca, soya and peanuts. This product has the appearance, the same "culinary assets" and the same protein content as that of rice. It is a palatable product which is cheaper and easier to produce than rice. —*Nutrition Notes.*

Patients appreciate the soft absorbent quality of

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HEAVY DUTY WHITE TERRY TOWELS

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for the service that they give. The heavy duty construction and selvedges hemmed for extra strength mean that they will stand up to countless launderings and that they will still be serviceable long after ordinary towels are washed out.

Also, they have a wide tape border which allows plenty of room for embroidering or stamping identification.

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Bath - 22" x 44" $10.20 doz.
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Discounts: 6 doz. less 5%, 12 doz. less 7%, 25 doz. or more less 10%.

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Twenty Years Ago

From "Canadian Hospital", March, 1940

One of the most unusual medical staff conferences, which was, at the same time, a most unique form of memorial meeting, was the memorial session of the staff of the Montreal Neurological Institute on February the 14th, 1940, in memory of the late Lord Tweedsmuir. The speakers on this memorial meeting focussed their attention upon the scientific aspects of his last illness, and those who had been in charge of his care at the institute during the last few days explained to their colleagues the efforts to bring about a recovery. Dr. Wilder Penfield reviewed the procedures adopted to relieve pressure and referred to the fact that twice His Excellency showed evidence of regaining power in the paralysed muscles. After the third operation he was again beginning to show evidence of recovery when an embolism from an unsuspected source defeated all of the efforts made. Other speakers were Dr. William Cone, Dr. Jonathon Meakins and Reverend David Scott.

* * *

With the repeated savage attacks on Viipuri by the Russians, the fate of the new maternity hospital is a matter of anxiety to those who have followed with interest the planning and erection of this very modern and fully equipped obstetrical unit. It seems to be characteristic of the totalitarian armies, be they German, Jap or Russian, that they ruthlessly destroy hospitals, universities and any other evidences of humanitarian or cultural activities.

* * *

A popular monthly magazine has a column each month in which it picks out brilliantly worded sentences from current literature. Some of their choice, particularly the similes, are most refreshing. One of our administrators who has suffered long and in anything but silence, at the hands of various surgeons, writing to a friend recently, drew a graphic pen picture of herself when she said: "My torso looks like an animated shorthand lesson—completely surrounded by inflated inner tubes."

The enquiry bureau of the Canadian Red Cross searches throughout the world for missing persons. Hundreds of these people are successfully traced.

Educational Activities

(continued from page 42)

training medical record librarians and, if possible, to determine whether the present course is meeting the terms of the original outline set out by Dr. A. L. Swanson, then executive secretary of the Canadian Hospital Council, in his letter of October 8, 1952, to the W. K. Kellogg Foundation. Dr. Swanson wrote:

"There are individuals now employed in medical record departments who could benefit from such a program, thus giving better service to their hospitals and, in this way, to the patients. Many of these people lack the necessary education to secure full, formalized training but could, by virtue of obtaining the first year certificate in this extension course, greatly augment their knowledge and increase their ability to serve. Others with sufficient educational backgrounds may lack the necessary funds to take a full formal program, but could, under this extension method, complete the training which would enable them to write their examinations for the registered record librarian status. The projected extension course would in no way be offered as competition to the existing formal training courses. Those who have the necessary educational qualifications, and the time and money required, will continue to take the one-year formal course leading to the R.R.L. status much more speedily than under this extension method."

A committee of the board of directors was so appointed and invited to consider the following points:

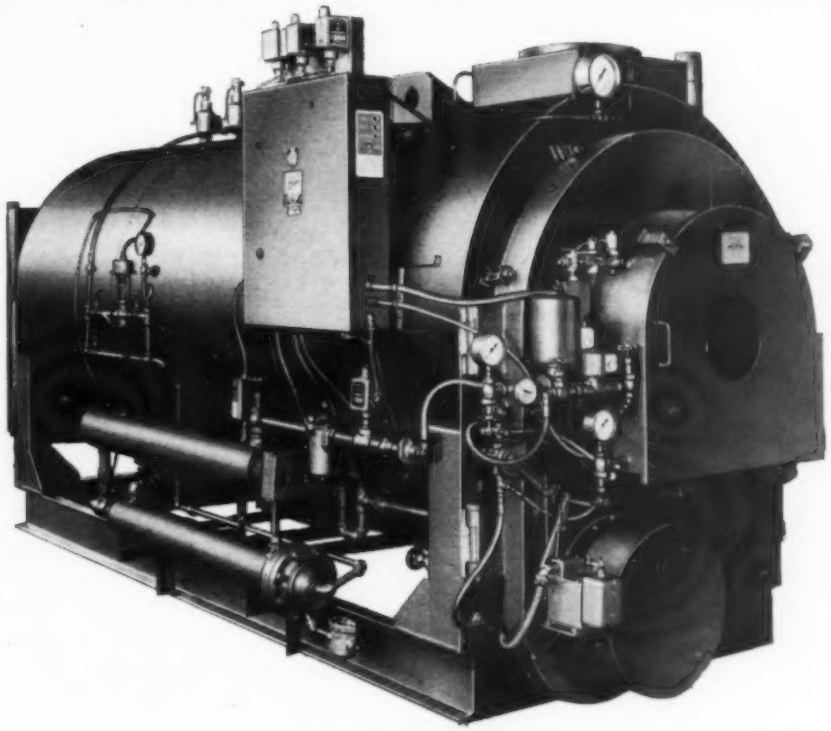
1. Re-evaluation of the intent of the course, which may change the relationship between the Canadian Hospital Association and the Canadian Association of Medical Record Librarians in the operation of the program.

2. Preparation of definite terms of reference, in which both the advisory and the administrative functions would be clearly delineated, with subsequent allocation of responsibility and authority. In establishing a working frame of reference, it would be expected that the responsibilities of Joint Committee members to both the committee and the course would be outlined.

3. If the program is to meet the needs of many of the medium and small hospitals, then its standards

(concluded on page 104)

Insist on NAPANEE



and *relax*

Automatically, your Napanee package boiler relieves you of all process steam worries. From the moment it arrives on the job, ready to go to work, its automatic controls take over to ensure fast, economical operation. Simplified engineering cuts maintenance and shut-down costs to a minimum. Since 1912, Napanee Iron Works has enjoyed a reputation for engineering perfection in the boiler field in Canada, where it is now the leader. That reputation is pledged in the certificate of guarantee that goes with every boiler. And backing that guarantee is a service organization at your beck and call 24 hours a day, seven days a week.

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Educational Activities

(concluded from page 102)

must be re-evaluated so that these students could be accepted for either one or two years. Then, upon successfully completing the course, they would be eligible to receive a certificate. By lowering the educational standard of the extension course, the registration activity of the Canadian Association of Medical Librarians would not be endangered because they would continue their own registration standard.

4. The present financial situation must be considered. To bring the course closer to a balanced budget, it is recommended that more students be accepted, particularly from small hospitals. In addition it is requested that consideration be given to withdrawal of the honorarium paid to either the hospital or the medical record librarian for conducting intramural sessions. By doing so, on the basis of the current budget, we could save a substantial sum of money.

5. It is felt that a considerable saving could be effected if the program could make use of a consultation and work committee to review, revise, and prepare lesson assignments and examinations. By using a voluntary committee whose members would receive only a token honorarium, the position of a full-time course supervisor would not be necessary. This is one of the definite and major contributions which the Canadian Association of Medical Record Librarians could make to the operation of the program.

4. Extension Course in Nursing Unit Administration

During the past two years, representatives of the Canadian Nurses' Association and the Canadian Hospital Association have discussed and recently formalized a proposal for the inauguration of an extension course for head nurses. This is to be a one-year combination intramural and correspondence course. The proposed program will use workshop methods and written lessons to present various principles and techniques of supervision to a large group of head nurses and assistant head nurses who would normally not be able to attend formal university programs.

At a meeting in Ottawa on February 17th, Alice Girard, president of the Canadian Nurses' Association and Stanley W. Martin, president of the Canadian Hospital Association, jointly announced that this course will be sponsored for a four-year period beginning July 1st, 1960. It was also announced that Kathleen Ruane, now director of nursing at the University Hospital in Saskatoon, has been appointed director of the new course.

It is expected that development of workshop and lesson material will take approximately one year. During this period pilot lessons will be reviewed and evaluated by various groups, including nurses and administrators, to ensure that proposed assignments are practical. The course will be offered to a limited number of nurses in September, 1961, and it is expected that an increasingly larger number of students will be accepted in subsequent classes. More complete information regarding this new course will be published in these pages as the program develops.

Laboratory Course in Medical Mycology

The Department of Bacteriology and Immunology, McGill University, Montreal, Que., will offer a four-week course in medical mycology, beginning May 2, 1960. The course is designed to give laboratory workers the opportunity to learn something about this subject.

Conducted by Dr. F. Blank and Dr. L. Kapica, the course will consist of lectures and practical laboratory work. It will comprise an introduction to general mycology, mycological techniques and the study of fungi causing disease in man and animals.

Applications should be submitted before April 15, 1960. The fee is $50.00.

(continued from page 48)

eral Hospital, while professor of psychiatry. He was later dean of medicine in the University of Toronto.

With the establishment of the Toronto Psychiatric Hospital under the joint auspices of the Government, the City of Toronto, and the University, a post-graduate program in psychiatry was established. A post-graduate course was established after World War II at the University of Western Ontario, and similar courses were commenced recently at the University of Ottawa and Queen's University. All of these collaborate with the Mental Health Division of the Department of Health in the training of psychiatrists.

The first training school for asylum nurses was begun in Kingston in 1887. In 1903, a nurse training school was set up in Brockville. In subsequent years, similar schools were established in six other mental hospitals. Of these, only three, giving courses leading to the R.N., remain. However, all hospitals now give formal in-service training to nurse aides and attendants.

In 1932, courses for affiliate nurses from general hospitals were begun at the Toronto Psychiatric Hospital. The Ontario Hospital, London, undertook to train affiliate nurses in 1937. Since 1947, affiliation courses have extended rapidly, and at the present time eleven mental hospitals provide a three month affiliation course for about 1,400 general hospital nursing students each year.

It is difficult to determine when summer internships in mental hospitals were first introduced, but over a period of forty years or more many medical students first became interested in psychiatry through this kind of experience. As departments of psychology, social work, and occupational therapy, were developed, internships were also made available to students in these disciplines.

With the introduction of national health grants in 1951, bursaries for post-graduate training in psychology, psychiatry, social work, and nursing, were made available.

Since January 1953, a training school for occupational therapy assistants, at the Ontario Hospital, Kingston, has trained 233 persons from Ontario hospitals and from other provinces.

Since 1933, arrangements for caring for mentally ill patients in

the community, but under the supervision of the hospital, have existed in the form of "boarding homes". In some instances, these functioned as convalescent or "halfway" houses, in other instances as domiciliary care facilities.

Since the establishment of travelling mental health clinics in 1930, out patient services have gradually expanded, but the expansion has accelerated since 1950 and the variety of services has increased. More attention is also being given to rehabilitation services, and the number of staff devoting their full time to these activities has increased considerably in the past decade. These various community services will be discussed more fully in one other articles in this series.

As a final note, mention should be made of the official recognition given to the broader aspects of the mental health field by the establishment, in 1955, of the post of Director of Community Mental Health within the Mental Health Division. Perhaps, of even more significance, is the fact that for the first time in the history of Ontario, the Minister of Health, in the 1959 session, presented to the Legislature an outline of a broad, long term program for the development of Mental Health Services. This statement provides the blue print for the revision and expansion of services in the foreseeable future. ■

U.K. Hospitals Fight Cross Infection

An experiment to determine the best methods of cleaning hospitals in order to cut down on cross infection is to be carried out in four British hospitals—Ashford, Staines and Hounslow, all in Middlesex, and St. Peter's Hospital, Chertsey, Surrey. By using different methods and types of cleaning equipment and sampling the air in each ward, pathologists hope to find out which type and method is best suited to fight cross infection.

This investigation is being financed and sponsored by the King Edward Hospital Fund of London. Three types of cleaning equipment will be used: a small type of suction cleaners, floor mop sweepers treated with a substance which causes dirt to cling to the mop and a material which, draped on a cleaning tool, works in much the same way as floor mop sweepers. The experiment is expected to last about six months. — *U.K. Information Service.*

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 57 Bloor Street West, Toronto 5, Ontario. Rates for classified advertisements are as follows:

$3.75 per column inch or fraction thereof, minimum charge $3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no additional charge, ¼ page display advertisement — $25.00. Advertisements must be received by the first of the month to appear in that month's issue.

POSITIONS OPEN

Three positions for Administrative Officers are now open in a large teaching hospital in the Province of Ontario. Good personnel policies and salary in accordance with experience. Graduates in Hospital Administration are preferred. Replies will be kept in strictest confidence. Vacancies—

(a) Assistant Superintendent (Medical)

(b) Administrative Assistant

(c) Administrative Assistant (Personnel)

Apply Box No. 0315,
Canadian Hospital,
25 Imperial Street,
Toronto 7, Ontario.

Can I Help You?

Hospital Construction Manager. Fourteen years experience. All phases of hospital construction, including planning, co-ordinating and managing construction contracts. Also qualified in supervision of hospital buildings and services. For further details please write Box H304, Canadian Hospital, 25 Imperial Street, Toronto 7, Ontario.

POSITION OPEN

The Victoria Union and Holy Family Hospitals, Prince Albert, Saskatchewan, require the services of a certified Pathologist to take complete charge of the laboratory department of the Victoria Union Hospital. Apply stating qualifications to: H. H. Bassett, Secretary, Board of Directors,

Victoria Union Hospital,
Prince Albert, Saskatchewan.

DIRECTOR OF NURSING

Modern 100 bed, non-teaching, general hospital located in beautiful Rideau Lakes region. One hour's drive to Capital city. Live in or out. Pension plan. No construction problems. Salary open and dependent upon qualifications and experience. References required. Apply giving full particulars to: Administrator,

Smiths Falls Public Hospital,
Smiths Falls, Ontario.

Therapeutic Dietitian Wanted

Experienced Dietitian required for 150 bed hospital, Greater Vancouver area. C.D.A. Membership preferred. Salary commensurate with qualifications and experience. Please apply in writing, giving full details to: Mrs. E. Rigby, Chief Dietitian, North Vancouver General Hospital, North Vancouver, B.C.

DIETITIAN REQUIRED

for 180 bed teaching hospital to take full charge of newly installed centralized food service. Also required to teach diet therapy to student nurses. QUALIFICATIONS: Eligible for membership in the Canadian Dietetic Association.

SALARY: Starting salary will be within the range of $350-$425 depending upon experience. APPLY TO: H. H. Bassett, Administrator,

Victoria Union Hospital,
Prince Albert, Saskatchewan.

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes inquiries from Hospital Trustee and Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

Dr. Johnson is trained and experienced in Hospital administration as well as Personnel Management and is available for Consultation of Personnel needs.

Our files contain many well qualified personnel as well as interesting openings.

We pride ourselves on careful screening of all clients and thorough investigation of openings. Our aim: to match the applicant and the specific position.

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Accountant—Office Manager
required by
Dryden District General Hospital

Ultra modern 50 bed hospital requires the services of a competent accountant to administer accounting records. Prepare monthly budget and operating statements, conduct purchasing routines and supervise account collections. The successful applicant will be responsible directly to the board of directors.

Recognized accounting training and experience in office management preferred, although not essential. This position offers a good opportunity for advancement in the field of hospital administration. Commencing salary is expected to be approximately $400.00 per month but will finally depend upon the applicant's qualifications.

Please reply giving full particulars of age, experience and education to

N. F. McAuley, Chairman, Board of Directors, Dryden District General Hospital, Dryden, Ontario.

Assistant Superintendent

Wanted for 73 bed General Hospital with planned expansion. Registered nurse with post graduate training and/or experience in supervision desired. Salary depending upon qualification and experience. For further particulars contact Superintendent, Kenora General Hospital, Kenora, Ontario.

X-Ray Technician Required

for 73 bed general hospital. R. T. essential, and experience in minor lab. procedures desirable. Salary range $265—$295. Apply to Superintendent, Kenora General Hospital.

CHIEF DIETITIAN

We require a qualified dietitian with membership in C.D.A. to head a modern dietary department. Hospital is situated in cultural and historic city of Kingston. Present accommodation consists of 500 beds, rising to 625 on opening of new wing in 1960. Hospital is fully accredited and has a nurses' training school.

Excellent personnel policies with 4 weeks' annual vacation, pension and medical plans. For further information, address enquiries to

Superintendent

KINGSTON GENERAL HOSPITAL
KINGSTON, ONTARIO

Borrowing and Lending

"NEITHER a borrower nor a lender be", was the ponderous and oft-quoted advice given by Polonius to his son Laertes, but many authorities feel that although Polonius was in earnest when he made this speech, Shakespeare had his tongue in his cheek when he wrote it.

As a lender of many years standing, the Canadian Red Cross Society is more in agreement with Shakespeare than with Polonius, because it has found that it can play an important part in the field of care for the sick of this country through its "Sick Room Loan Service".

The service offers free of charge the loan of all types of sick room articles, except electrical and specialized equipment. The list of items available includes hospital beds and mattresses, wheel chairs, crutches, canes, bed pans, urinals, rubber sheets, air rings, back rests, bed trays, baby scales and breast pumps.

Most loans are made for a period of one month, though they can be renewed if they are still required by the patient. Loan of hospital beds is usually limited to four months and wheel chairs to three months, and neither is subject to renewal. For obvious reasons, the Red Cross prefers to lend its equipment on the advice of the hospital or the doctor in charge.

The reason why some people dislike lending is that articles are not returned. However, the Red Cross, like a public library, finds that its losses are remarkably few. Most people accept the obligation to return what they borrow, and usually do so with the article in excellent condition.

Through the loan service, the Red Cross often follows a patient's progress from the hospital bed stage, through wheel chair, crutches and cane, to returned health. Advice about methods of using the articles loaned is also available to the home nurse, and, of course, the loan service is closely linked with home nursing courses in which instruction in simple nursing procedures is given.

Loans are available to farm and small town residents as well as to city dwellers. Sick room loan cupboards are maintained by Red Cross branches in hundreds of centres across the country. Generally the larger pieces of equipment are held in the larger towns and cities, and despatched on request to patients in smaller places.

The Red Cross makes no means test and its service is available to all who need it, regardless of financial condition, but in most cases, loans are made to people who would struggle along without the equipment if a charge were made—to the discomfort of the patient and the needless frustration of the home nurse.

The loan service is a practical society as a whole. Crutches were one from the point of view of loaned by the Red Cross in Manitoba, to a three-year-old. To purchase a pair of crutches when a three-year-old member of the family breaks a leg is impractical. Chances are that the same person will not injure himself again in a way that will call for crutches a second time, and if he does he may have outgrown them. Nor are they apt to be the right size for any other person in the family.

Similarly, any other piece of sick room equipment might be required once in a life time, and would be left to gather dust in the attic for the next quarter-century, or until the family moved to a new home.

Many hospitals find the Red Cross Sick Room Loan Service an excellent means of providing the best possible care for their patients after discharge. In Manitoba, the Red Cross works very closely with some of the larger hospitals, particularly in loaning crutches. Details of the patient's needs are telephoned by the hospital to the Red Cross and equipment is provided in time for the patient's return home.—*Margaret Allen.*

Margaret Allen, formerly public relations officer with the Manitoba Division, Canadian Red Cross Society. ■

News Released by Hospital Supply Houses

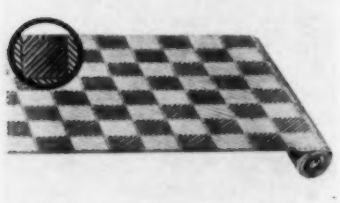
By C.A.E.

Traffic-Master
Heavy Duty Matting

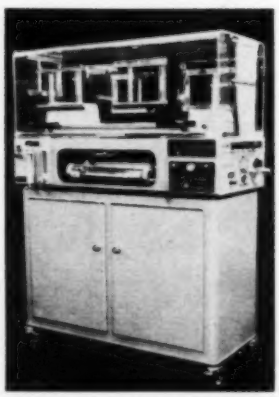
Gordon D. Hay, vice-president and general manager of Gordon A. MacEachern Limited, announces the inclusion of the new Traffic-Master to their line of mats and matting.

The Traffic-Master reversible matting features deeply molded ribbed 6″ squares, set in alternate block design to give a smart checkerboard effect. This new design reduces cleaning and maintenance cost because dirt and mud are trapped, thereby reducing damaging wear to expensive tile, carpet, wood, and other types of fine flooring.

This new matting has positive non-skid, non-slip walking surface with foot-cleaning squeegee action and is reversible for installation over such floorings as broadloom, et cetera. Made of live, top quality rubber the Traffic Master will hold up for years under the most severe usage.



It is distributed in Canada by Gordon A. MacEachern Limited. This matting is now available in five colours—green, beige, black, grey and red. It comes in 36″ and 48″ widths.



Draeger Incubators Available in Canada

The Draeger Corporation of Germany, manufacturers of breathing and anaesthesia equipment, have opened headquarters in New York and in Montreal. The Draeger group manufactures over 100 pieces of medical apparatus and equipment for the paediatric and gynaecological wards, operating theatre, recovery room and other departments of hospitals.

The Canadian sales distributors are United Surgical Supplies Limited of Montreal, Que. Distributors for eastern Canada are J. F. Hartz Co. Ltd., Halifax, Montreal and Toronto, Fisher & Burpe, Toronto and Montreal, and Casgrain and Charbonneau Ltée, Montreal and Quebec. The distributors for western Canada are now being appointed.

Draeger paediatric apparatus is already available in Canada, including the DeLuxe Incubator, the electric bassinet Babytherm and portable baby incubator. The DeLuxe Draeger Incubator features a built-in precision balance so that the babies do not have to be touched by hands and is equipped with a unique visual and acoustical electric control and warming system. The controls are part of an electronic power unit which can be exchanged within minutes in case of breakdown.

United Surgical Supplies Ltd., together with their distributors, will gradually introduce on the Canadian market a great variety of Draeger equipment apparatus in the field of breathing and anaesthesia.

X-Ray and Radium Limited
Now Employee Owned

X-Ray and Radium Limited, a new company, has been formed to take over the activities formerly carried on by X-Ray and Radium Industries Limited.

The former company has been engaged in the field of sales and service for x-ray equipment and accessories and has specialized in electrocardiograph and metabolism instruments, electro-medical and physiotherapy instruments, electro-encephalographs and hospital supply equipment. The company has also been engaged in the preparation of radium for medical and industrial use and the manufacture of specialties such as aircraft dials and edge lighted instrument panels.

C. B. French, president, announced the formation of the new company and the acquisition of the assets of the former company by X-Ray and Radium Limited. The new company will carry on the unique combination of sales and service of medical equipment, together with its well established radium business in Canada.

X-Ray and Radium Limited is the exclusive Canadian representative of Westinghouse Electric International Company, the manufacturers of Westinghouse x-ray equipment, and the Sanborn Company, manufacturers of cardiographs and other multichannel recording equipment.

Plants are maintained by the company in Toronto, Montreal and Vancouver, and there are offices in all the principal cities of Canada.

The officers of the company are: Carl B. French, president; Harry M. McLean, vice-president; and Norman F. Hall, treasurer. The following directors of the company have been elected: Carl B. French, Harry M. McLean, Norman F. Hall, James T. Garrow, Q.C., and Mrs. Ruth A. French.

New General Electric Facility Dedicated

A pledge to the people of Canada —to provide full co-operation in the development of x-ray equipment to support modern medicine's never ending march against disease—was promised at the dedication of a new office and service facility. The building, located at 78 Rivalda Road, Weston, Ont., is the new home of the General Electric X-Ray Corporation Ltd., in the Toronto area.

According to J. W. Martin, G. E. X-Ray Toronto district manager, the new facility can be divided roughly into three main areas. The front one-third serves as general office, showroom, sales office and district manager's office. The centre third is allocated to service, with the remaining third housing stock room and shipping and receiving facilities.

The building has been fully equipped with the latest electronic test equipment, oscilliscope, multiple electronic test units as well as power tools. The shipping department utilizes truck-level loading facilities and stock shelves and pallets arranged for accessibility and handling with truck carts.

Conductive Inflation System

In answer to the question many hospitals and anaesthesiologists have asked about the conductivity of blood pressure cuffs used in operating areas, W. A. Baum Co. have introduced the Baumanometer conductive V-Lok inflation system developed to reduce operating room hazards. Every component of the blood pressure accessory is conductive—fully tested and approved as safe for use in anaesthetizing areas. V-Lok cuff is made of finely woven fabric coated on both surfaces with conductive neoprene and utilizing the new Velcro closure. Bulb, bag and tubing are all seamless, dipped conductive Latex. They can be used with any blood pressure instrument and are available through hospital and surgical supply dealers.

Illustrated literature is available from the manufacturer, W. A. Baum Co., Copiague, N.Y.

Kodak Introduces New Method for Reproducing Documents

Canadian Kodak has announced a new photographic system for use in reproducing documents in quantities of 10 to 1,000. Known as the Ektalith Method, it is a versatile system which can be used to reproduce all types of documents, from letters to engineering drawings, in either room-light or darkroom. It can rapidly make inexpensive paper masters for offset reproduction or it can make a limited number of direct copies without using the offset process.

In two minutes this method can produce a master from practically any type of original—printed, typed, written, or drawn on opaque or translucent paper—in enlarged, reduced, or the same size. An accessory copying unit is available for making high quality direct copies when up to ten copies are required.

The Ektalith line will be available through Kodak Ektalith dealers. For further information on sources of this equipment or of the duplicating equipment required, contact Canadian Kodak Sales Limited, Toronto 15, Ont.

Lily Disposable Pitcher

Lily Cups Ltd. have introduced a disposable pitcher for hospital use that matches the traditional Greenleaf design of their other beverage service. The new pitcher holds a quart of liquid, is light in weight and is easy to handle when full. A snap-on stainless steel lid lets liquids flow freely while keeping ice in. The lid-handle unit may be removed readily for sterilization. The pitcher is a natural insulator, keeping liquids cool and fresh for hours.

For more information write to the Institutional Department, Lily Cups Ltd., 300 Danforth Rd., Toronto 13, Ont.

New Skull Positioning Unit

After two years of research, a new skull positioner is available to Canadian hospitals. According to its inventor, this is the first advance of this kind in over 35 years, and it has been developed and manufactured in Canada.

The unit offers maximum patient comfort. The patient's head rests in polyurethane foam inserts for all positions. It cuts the time for routine skull views in half and means film economy since no repeat films are necessary. There is accurate positioning of the patient and radiograph, on the film and because of the standardization of positions, more positive diagnosis is possible. With the unit is a new wall chart and radiologist's desk chart.

This unit is manufactured by Ren-Ray Company, Long Sault, Ont., and is available through all x-ray dealers.

Purkett Improves Tumbler

New improvements on the Windjammer tumbler, which is the 72-inch, 25-ring, pre-drying conditioning type for large capacity laundry installations, have been announced by the Purkett Mfg. Co., Inc., Joplin, Mo.

On the new machine the gas steam line has been increased two-thirds to 1¼" size. The doors have been completely perforated and a back chamber added to prevent the clogging of lint, and this feature, coupled with the new cleanouts in the vents, now provides more complete drying with faster cycling time.

The new improvements in the air cylinder system have given a more positive action to sealing the doors against the inside pressure.

Blood Pressure Monitor

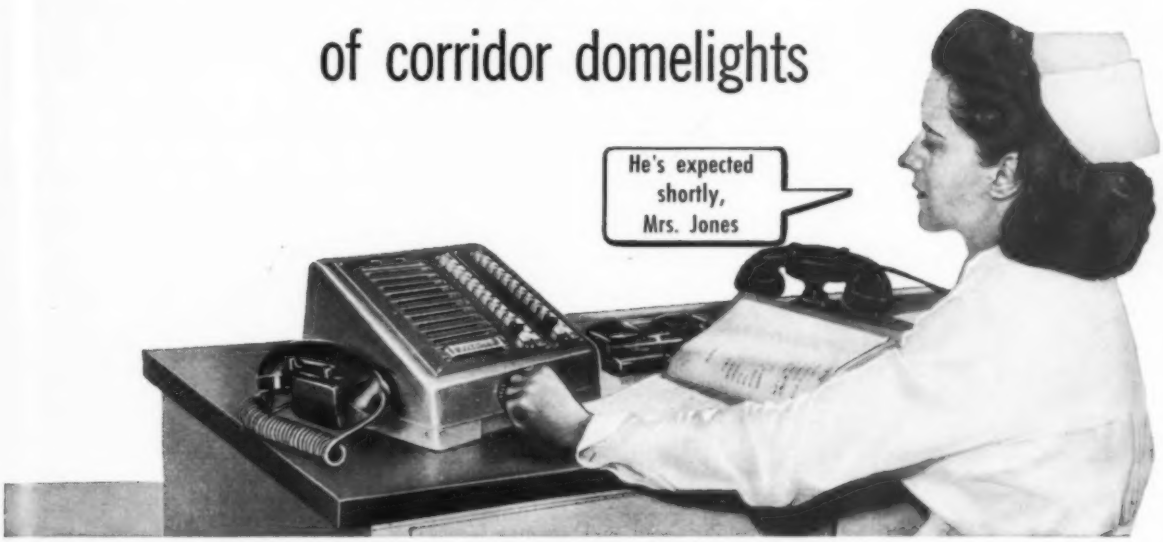
A new painless blood pressure follower has been invented by Dr. J. H. Green of the Middlesex Hospital Medical School, London, England. It can be used even while the patient is asleep. The instrument provides constant observation

Add **AUDIO** easily

to your present

VISUAL nurse call system

of corridor domelights



Executone's DEPENDABLE Audio-Visual Nurse Call System Cuts Foot Travel in Half!

Easily and quickly added to your present visual domelight system, Executone frequently uses *existing* conduits or raceways—providing you with a *modern* Audio-Visual Nurse Call System! All accomplished with no interruption of service during installation!

Many hospitals—old and new—are discovering the economy and efficiency of Executone's Audio-Visual system. More patients are handled with *less effort, in less time!* One hospital reports that Executone has reduced operating costs 8% per bed. *It is an invaluable aid in relieving the nurse shortage.*

By pressing a bedside button, the patient activates signals at three locations—chime and light on nurse's control station, corridor domelight, buzzer and light on duty stations. The nurse presses key to reply . . . Executone's Call System may be installed complete, added to existing domelight systems, or installed without domelights.

Just off the press!

"Better Patient Care"

How Executone communications help hospitals improve patient care and make maximum use of nursing time and skills. Includes a summary of time and motion studies of Executone Audio-Visual Nurse Call Systems made by the Surgeon Generals' offices of the Army and Air Force. Also described and illustrated are Doctors' Paging Systems, Bedside Radio-Sound Systems, Departmental Administrative Systems. Send in the coupon below for your complimentary copy.

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Without obligation, please send me a complimentary copy of "Better Patient Care."

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The monitor has a control panel on which there are two dials—one is set to the lowest permissible blood pressure and the other to the highest. If the patient's blood pressure fluctuates beyond these limits an alarm system of lights or bells starts and the supply of drugs is cut off.

By means of its automatic regulation and control abilities, therefore, the blood pressure follower

and gives forewarning of dangerous changes in blood pressure level. It also permits the regulation of the supply of drugs to the patient to maintain a predetermined blood pressure level.
can be set to produce a required blood pressure level for a specific purpose over a specified period.—*Courtesy the U.K. Information Service.*

Ontario Bulk Sales Manager for Stafford Foods

John H. Stafford, president of Stafford Foods Limited, has announced the appointment of Ronald Lake as Ontario bulk sales manager. Mr. Lake has been with Stafford Foods for 14 years, serving as branch manager, Vancouver, for the past eight years. In his new capacity he will be responsible for the company's rapidly expanding sales force, serving hospitals, institutions and restaurants.

Hobart Appointment

Harry C. Pharoah has been appointed vice-president and corporate officer of the Hobart Manufacturing Company Limited. He will also continue in his administrative duties as general sales manager.

New Western Representative for Braun

Braun of Canada Equipment Limited has announced the appointment of Dave West as western representative. This move coincides with the recent appointment of Bill Grant as sales manager, with headquarters in Toronto.

Dave West is well known as an outstanding Big-Four football player. He played for Toronto Argonauts, Hamilton Tiger Cats and the Ottawa Roughriders.

Mr. West received his photographic training at the Brooks Institute and at Camera Crafts in Kitchener where he became store manager.

Stanley Brock Appointment

D. M. Drinnan, president and general manager of Stanley Brock Limited, recently announced the appointment of Albert W. Miller, B.Sc., M.C.I.C., P.Eng., to the position of vice-president and assistant general manager. Mr. Miller has held the position of technical director with the company since 1952, and in addition has been in charge of sales promotion and advertising during this time. He was appointed to the board of directors in 1958.

Air Pollution Study

A scientifically equipped, 200-foot tower has been installed by the Occupational Health Division of the Department of National Health and Welfare at the agrometeorological site on the Central Experimental Farm, Ottawa, Ont. Measurements of wind speed, wind gustiness, turbulence, temperature and certain air pollutants will be taken at various levels along the tower for correlation with studies of the levels of air pollution contaminants and their dispersion under various environmental conditions that have been undertaken by the Occupational Health Division. The studies will also be used by the Research Branch of the Department of Agriculture in connection with the diffusion of heat and water vapour through the atmosphere and the dispersion of flying insects, pollen, and airborne plant disease organisms.

A new monument at Solferino, Italy, commemorates the birth of the Red Cross idea and honours Henri Dunant, the founder of the Red Cross.

INDEX OF ADVERTISERS

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